Filing at a Glance

Company:	Coventry Health and Life Insurance Co.
Product Name:	AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider
State:	Arkansas
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.001A Any Size Group - PPO
Filing Type:	Form
Date Submitted:	07/20/2012
SERFF Tr Num:	CVLA-128476517
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	062012 - 05
Implementation Date Requested:	On Approval
Author(s):	Nancy Bourgeois
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	07/20/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

General Information

Project Name: AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider

Project Number: 06132012 - 02

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 07/20/2012

State Status Changed: 07/20/2012

Created By: Nancy Bourgeois

Corresponding Filing Tracking Number: 46993 and 48338

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Nancy Bourgeois

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

Dear Ms. Minor,

I am writing on behalf of Coventry Health and Life Insurance Company to seek approval for the following revised Group PPO documents:

TNARMS Merged Employer Group Application -- TNARMS Group App -05.2012 (submitted in 2 parts)
TNARMS GROUP Enrollment Form (2-25) -- TNARMS-ENRL (2-25) -06.2012
TNARMS GROUP Enrollment Form (26-99) -- TNARMS-ENRL (26-50) -06.2012
TNARMS GROUP Enrollment Form (99+) -- TNARMS-ENRL (99+) -06.2012

The following are new Group PPO documents also being submitted for approval:

TNARMS GROUP Non-ERISA Addendum -- TNARMS Non-ERISA ADD. -05.2012
AR-MS Small Group Online Subscriber Application (submitted in two parts) -- Part 1 -AR-MS Sm.Grp.Online.Sub.Ap. -05.2012 and Part 2 -AR-MS Sm.Grp.Online.Sub.Ap. -05.2012
TNARMS GROUP Enrollment/Change Form -- LATNARMS Enroll -05.2012
TNARMS GROUP Enrollment/Change Form (99+) -- LATNARMS Enroll - 05.2012 (99+)
AR GROUP Autism Rider -- AR CHL GROUP PPO –Autism Rider -06.2012
LA-TNARMS Women's Preventive Amendment -- LA-TNARMS –WP AMEND. -07.2012

All forms being submitted are to be used in conjunction with the following previously approved Form Numbers:

CHAR 00006 (4/09) --Employer Risk Questionnaire 51+ approved by the Arkansas Insurance Department on 5/29/09.
TN AR MS Group PPO_COC_10_CHL (9/2010) --COC approved by the Arkansas Insurance Department on 10/25/10 as part of form filing # 46993.
TNARMS SOB10_CHL (9/2010) --SOB approved by the Arkansas Insurance Department on 10/25/10 as part of form filing #

46993.
TN AR MS-DOMPART-08/2010 --Domestic Partner Rider approved by the Arkansas Insurance Department on 10/25/10 as part of form filing # 46993.
TN-AR-MS_RX11_CHL --Rx Drug Rider approved by the Arkansas Insurance Department on 3/30/11as part of form filing # 48338.

Please do not hesitate to contact me with any issues or questions.

Best regards,
Nancy G. Bourgeois
Tel. (504) 834-0840 Ext. 2138

Company and Contact

Filing Contact Information

Nancy Bourgeois, Regulatory Compliance Documents Coordinator
3838 N. Causeway Blvd.
Suite 3350
Metairie, LA 70002

ngbourgeois@cvty.com

504-834-0840 [Phone] 2138 [Ext]

Filing Company Information

Coventry Health and Life Insurance Co.
5350 Poplar Ave.
Suite 390
Memphis, TN 38119
(901) 462-2380 ext. [Phone]

CoCode: 81973
Group Code:
Group Name:
FEIN Number: 75-1296086

State of Domicile: Delaware
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$500.00
Retaliatory?	Yes
Fee Explanation:	Ten (10) forms x $50.00 = $500.00. Delaware is our domicile state, and the fee is $50.00 per form.
Per Company:	No

Check Number	Check Amount	Check Date
2018	$400.00	06/22/2012
2031	$100.00	06/28/2012

SERFF Tracking #:	*CVLA-128476517*	***State Tracking #:***		***Company Tracking #:***	*062012 - 05*

State:	*Arkansas*	***Filing Company:***	*Coventry Health and Life Insurance Co.*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*		
Product Name:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider*		
Project Name/Number:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider/06132012 - 02*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/20/2012	07/20/2012

SERFF Tracking #:	*CVLA-128476517*	***State Tracking #:***		***Company Tracking #:***	*062012 - 05*
State:	*Arkansas*		***Filing Company:***	*Coventry Health and Life Insurance Co.*	
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*				
Product Name:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider*				
Project Name/Number:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider/06132012 - 02*				

Disposition

Disposition Date: 07/20/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Part 1 - TNARMS Merged Empl. Grp. Applic - pgs. 1-2	Approved-Closed	Yes
Form	Part 2 - TNARMS Merged Empl. Grp. Applic - pg. 3	Approved-Closed	Yes
Form	TNARMS GROUP Non-ERISA Addendum	Approved-Closed	Yes
Form	Part 1 -AR-MS Sm. Grp.Online.Sub.Applic. (pgs. 1-17)	Approved-Closed	Yes
Form	Part 2 -AR-MS Sm. Grp.Online.Sub.Applic. (pgs. 18-33)	Approved-Closed	Yes
Form	TNARMS GROUP Enroll./Change Form	Approved-Closed	Yes
Form	TNARMS GROUP Enroll./Change Form (99+)	Approved-Closed	Yes
Form	TNARMS CHL GRP. PPO Enroll. Form (2-25)	Approved-Closed	Yes
Form	TNARMS CHL GRP. PPO Enroll. Form (26-99)	Approved-Closed	Yes
Form	TNARMS CHL GRP. PPO Enroll. Form (99+)	Approved-Closed	Yes
Form	AR GROUP Autism Rider	Approved-Closed	Yes
Form	LA-TNARMS - Women's Preventive Amendment	Approved-Closed	Yes

SERFF Tracking #:	*CVLA-128476517*	***State Tracking #:***		***Company Tracking #:***	*062012 - 05*
State:	*Arkansas*		***Filing Company:***	*Coventry Health and Life Insurance Co.*	
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*				
Product Name:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider*				
Project Name/Number:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider/06132012 - 02*				

Form Schedule

Lead Form Number: TNARMS Group App -05.2012

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 07/20/2012	TNARMS Group App - 05.2012	AEF	Part 1 - TNARMS Merged Empl. Grp. Applic - pgs. 1-2	Revised: Replaced Form #: CHTN 00043 (3/11) Previous Filing #: Approved 3/30/11 - form filing ID #48338		6.25.12 - TNARMS Merged Ap.for Benefits-pgs.1-2.pdf
2	Approved-Closed 07/20/2012	TNARMS Group App - 05.2012	AEF	Part 2 - TNARMS Merged Empl. Grp. Applic - pg. 3	Revised: Replaced Form #: CHTN 00043 (3/11) Previous Filing #: Approved 3/30/11 - form filing ID #48338		6.25.12 - TNARMS Merged Ap.for Benefits-pg.3.pdf
3	Approved-Closed 07/20/2012	TNARMS Non-ERISA ADD. - 05.2012	AEF	TNARMS GROUP Non-ERISA Addendum	Initial:		7.19.12 CL.rev.ft.-recd.6.29.12 frTh.-TNARMS Non-ERISA ADD..pdf
4	Approved-Closed 07/20/2012	Part 1 -AR-MS Sm.Grp.Online. Sub.Ap. - 05.2012	AEF	Part 1 -AR-MS Sm. Grp.Online.Sub.Applic. (pgs. 1-17)	Initial:		7.19.12 - rev.ft.CL-5.1.12 CL--AR-MS-Sm.Grp.Online.Sub.Ap.1.pdf
5	Approved-Closed 07/20/2012	Part 2 -AR-MS Sm.Grp.Online. Sub.Ap. - 05.2012	AEF	Part 2 -AR-MS Sm. Grp.Online.Sub.Applic. (pgs. 18-33)	Initial:		7.19.12 - rev.ft.CL-5.1.12 CL--AR-MS-Sm.Grp.Online.Grp.Ap.2.pdf

SERFF Tracking #:	*CVLA-128476517*	***State Tracking #:***		***Company Tracking #:***	*062012 - 05*
State:	*Arkansas*		***Filing Company:***	*Coventry Health and Life Insurance Co.*	
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*				
Product Name:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider*				
Project Name/Number:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider/06132012 - 02*				

Lead Form Number: TNARMS Group App -05.2012

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
6	Approved-Closed 07/20/2012	LATNARMS Enroll -05.2012	AEF	TNARMS GROUP Enroll./Change Form	Initial:		6.25.12 - CHC Edited2--TNARMS Enr.Fm.w.Int..pdf
7	Approved-Closed 07/20/2012	LATNARMS Enroll -05.2012 (99+)	AEF	TNARMS GROUP Enroll./Change Form (99+)	Initial:		6.26.12 - CHC Edited2--TNARMS Enr.Fm.w.Int.99+.pdf
8	Approved-Closed 07/20/2012	TNARMS-ENRL (2-25) - 06.2012	AEF	TNARMS CHL GRP. PPO Enroll. Form (2-25)	Revised: Replaced Form #: CHAR 00001 (originally approved 2/11/08) Previous Filing #: Approved 10/25/10 - form filing #46993		6.20.12 - TNARMS 2-25 Enroll.Form.pdf
9	Approved-Closed 07/20/2012	TNARMS-ENRL (26-50) - 06.2012	AEF	TNARMS CHL GRP. PPO Enroll. Form (26-99)	Revised: Replaced Form #: CHAR 00002 and CHAR 00003 (originally approved 2/11/08) Previous Filing #: Approved 10/25/10 - form filing #46993		6.20.12 - TNARMS 26-99 Enroll.Form.pdf
10	Approved-Closed 07/20/2012	TNARMS-ENRL (99+) - 06.2012	AEF	TNARMS CHL GRP. PPO Enroll. Form (99+)	Revised: Replaced Form #: CHAR 00004 (originally approved 2/11/08) Previous Filing #: Approved 10/25/10 - form filing #46993		6.26.12 - TNARMS 99+ Enroll.Form.pdf

SERFF Tracking #:	*CVLA-128476517*	***State Tracking #:***		***Company Tracking #:***	*062012 - 05*
State:	*Arkansas*		***Filing Company:***	*Coventry Health and Life Insurance Co.*	
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*				
Product Name:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider*				
Project Name/Number:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider/06132012 - 02*				

Lead Form Number: TNARMS Group App -05.2012

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
11	Approved-Closed 07/20/2012	AR CHL GROUP PPO –Autism Rider - 06.2012	CERA	AR GROUP Autism Rider	Initial:		6.27.12 - CLEAN w.logo-ft-sign.--AR CHL GRP.PPO-Autism Rider.pdf
12	Approved-Closed 07/20/2012	LA-TNARMS –WP AMEND. - 07.2012	CERA	LA-TNARMS - Women's Preventive Amendment	Initial:		7.13.12 -CLEAN- LA-TNARMS -WP AMEND. - 07.2012.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

COVENTRY® Health Care
Coventry Health and Life Insurance Company

APPLICATION FOR BENEFITS OFFERINGS

Incomplete information will delay processing application

Application is hereby made to Coventry Health and Life Insurance Company (CHL) by the Applicant named herein for the purpose of making CHL available to provide access to certain health and other benefits as specified below. CHL's issuance of the Group Enrollment Agreement (GEA) shall be based upon the information contained in this application. The GEA, Certificate of Coverage (COC) and Amendments, Enrollment/Change Form, Applicable Riders, Member Handbook, Provider Directory, and Schedule of Benefits will become the definitive agreement relating to the provision of health benefits during the term and any renewal terms of the GEA.

I. Group Information

Group No.:	Effective Date:	SIC Code:
Type of Organization:		Federal Tax ID #:
Company Name:		
Company Address: (Street / City / State / Zip)		
Telephone Number: ( )	Fax Number: ( )	E-Mail Address:
Billing Address: (Street / City / State / Zip)		
Prior/Current Health Insurer Carrier (for deductible credit):		
Dates of Coverage:	Annual Dedictible:	Administered Per: ☐ Contract Year ☐ Calendar Year

Is Coventry sole carrier for this group? ☐ Yes ☐ No Other Carrier _____

Administrative/Billing Contact: ☐ Mr. ☐ Ms.

Name _____

Title _____

Phone _____

Fax _____

Email _____

Decision-Maker (signs contract): ☐ Mr. ☐ Ms.

Name _____

Title _____

Phone _____

Fax _____

Email _____

Covered Subsidiaries: | Years in Business:

Employer Contribution	Employee	Employee & Spouse / Employee & One	Employee & Child(ren)	Family

Sold Rates	Employee	Employee & Spouse / Employee & One	Employee & Child(ren)	Family

II. Group Definitions:	Column 1	Column 2*
	ALL GROUPS MUST COMPLETE THIS COLUMN	Only Groups rated with 2 separate Classes of employees must complete this column **
Eligible Employees:	All full-time employees working ____ hours	All full-time employees working ____ hours
Waiting Period:	☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days	☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days
Effective Information:	☐ Date of Hire ☐ 1st day of calendar month following employment ☐ 1st day following waiting period ☐ 1st day of calendar month following waiting period (Applies to **0, 30, 60, 90, 120, 180** day waiting period only)	☐ Date of Hire ☐ 1st day of calendar month following employment ☐ 1st day following waiting period ☐ 1st day of calendar month following waiting period (Applies to **0, 30, 60, 90, 120, 180** day waiting period only)
Date Coverage Ends:	☐ Date of Termination ☐ Last day of calendar month following termination	☐ Date of Termination ☐ Last day of calendar month following termination
Retiree Coverage: Available to 51+ only	☐ Yes ☐ No	☐ Yes ☐ No
***Definition of Class I & Class II for Large Groups Only** (insert type, such as hourly)	Class I:_____	Class II:_____

III. Average Number of Eligible Employees (The same number as "total employees" field in Benefit Express)

Example: January 1 through December 31, 2009. This average must include all persons employed by the company in the preceding calendar year, whether an employee was full-time, part-time and/or seasonal. Important: the government requires the total average number, regardless of whether employees were eligible to enroll, and/or participated in the group insurance coverage. Only include temporary employees if they are employees of the company (i.e., employees to whom the employer issues a W-2). The average in the example below equals the total number of employees for 2009 divided by 12 months (e.g. 411 divided by 12 = 34.)

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average
FT Emp.	20	22	23	24	25	27	25	22	23	21	20	18	270	
PT Emp.	2	2	2	2	3	3	2	2	1	3	3	3	28	
Seasonal	1	1	1	0	0	0	0	0	0	30	40	40	113	
Total	23	25	26	26	28	30	27	24	24	54	63	61	411	34

Average

IV. Benefit Plans Selected:

IN-AREA	Plan Option 1	Plan Option 2	Plan Option 3	Plan Option 4
Base Plan:				
Pharmacy:				
Vision:				
[Dental:]				
# Enrolled in plan:				
OUT-AREA	Plan Option 1	Plan Option 2	Plan Option 3	Plan Option 4
Base Plan:				
Pharmacy:				
Vision:				
[Dental:]				
# Enrolled in plan:				

V. Eligibility Information

Total Eligible Employees: _____ Total Active Employees: _____ Retirees <65: _____

Total Enrolled Subscribers: _____ COBRA: _____ Retirees 65+: _____

Waivers: _____ Total Employees Not Actively at Work: _____

VI. Medical Loss Ratio (MLR) Classification

Check the appropriate box below. More information about MLR can be found at www.hhs.gov.

- ☐ ERISA
- ☐ Government Group - Non-Federal (A non-Federal governmental plan is plan that is established or maintained by the government of any State or political subdivision thereof for its employees, or by any agency or instrumentality of any government of any State or political subdivision for its employees).

Non-ERISA and not a Government Group (if you choose this option you must complete the Coventry non-ERISA addendum that will be provided and check one of the boxes below)

- ☐ Non-ERISA - Agree to the terms in the Coventry non-ERISA addendum.
- ☐ Non-ERISA - Don't agree to the terms in the Coventry non-ERISA addendum.

VII. Authorization

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

DO NOT CANCEL EXISTING GROUP INSURANCE UNTIL YOU HAVE BEEN NOTIFIED OF YOUR GROUP'S ACCEPTANCE BY CHCLA.
No rates shall go into effect until final rates have been determined and accepted.

Employer Signature:	Broker Signature:
Print Name:	Print Name:
Date:	Date:

[INSERT EMPLOYER NAME]
Insurer: Coventry Health and Life Insurance Company

Check the appropriate box, **only one box may be checked**:

☐ 1. The group benefit plan referenced above is neither subject to ERISA nor is it a non-Federal governmental plan and agrees to the terms and conditions set forth on the second page of this form. A non-Federal governmental plan is a plan that is established or maintained by the government of any State or political subdivision thereof for its employees, or by any agency or instrumentality of any government of any State or political subdivision for its employees. If you checked this box, sign below, complete the second page of this form and return both pages of this form to the address below.

☐ 2. The group benefit plan referenced above is neither subject to ERISA nor is it a non-Federal governmental plan as defined above, and does not agree to the terms and conditions set forth on the second page of this form. I understand that any refunds that may be due pursuant to the Act will be sent to the individual subscribers in my group and my group will not receive any such refunds. DO NOT COMPLETE THE SECOND PAGE OF THIS FORM.

RETURN THIS SIGNED FORM TO:

Coventry Health and Life Insurance Company
5350 Poplar Avenue
Suite 390
Memphis, TN 38119

I certify that I am an authorized representative of the employer group listed above, that I have knowledge of the information described above and the above information is correct and complete. I will notify Coventry Health and Life Insurance Company immediately if the above information changes or if it is discovered that the above information is incorrect or incomplete.

Signature:_____

Name:_____

Title:_____

Date:_____

[INSERT EMPLOYER NAME]
Insurer: Coventry Health and Life Insurance Company

ONLY TO BE SIGNED BY GROUPS THAT ARE NOT SUBJECT TO ERISA AND ARE NOT NON-FEDERAL GOVERNMENTAL PLANS (I.E., GROUPS THAT CHECKED THE FIRST BOX ON THE PRIOR PAGE). IF SUCH GROUPS DO NOT SIGN BELOW, ANY REBATES THAT MAY BE DUE YOUR GROUP PURSUANT TO THE AFFORDABLE CARE ACT WILL BE SENT TO THE INDIVIDUAL SUBSCRIBERS/EMPLOYEES AND YOUR GROUP WILL NOT RECEIVE ANY REBATE. THIS IS REGARDLESS IF YOUR GROUP CONTRIBUTED TO SOME OR ALL OF THE PREMIUMS PAID FOR YOUR EMPLOYEES' COVERAGE.

[INSERT EMPLOYER NAME] ("Employer") understands and agrees to the following with respect to any rebates Employer may receive from Coventry Health and Life Insurance Company pursuant to the requirements of the Federal Affordable Care Act:

Employer shall use that amount of the rebate that is proportionate to the total amount of premiums contributed by employees in one of the following ways:

i. For all employees enrolled under any health benefit plan option offered by Employer at the time the rebate is received, reduce the employees' portion of the premium for the subsequent policy year;

ii. For all employees enrolled under the health benefit plan option for which the rebate is being paid, reduce the employees' portion of the premium for the subsequent policy year;

iii. Provide a cash refund to employees enrolled under the health benefit plan option for which the rebate is being paid;

The reduction in future premiums or cash refund described in i., ii., or iii., above, may, at the option of Employer, be divided evenly among such employees, divided based on each employees actual contributions to premium, or apportioned in a manner that reasonably reflects each employee's actual contributions to premium.

Employer understands and agrees that the portion of rebate based upon former employees' contributions to premiums must be aggregated and used for the benefit of current employees as described in i., ii. and iii. above.

ACKNOWLEDGED AND AGREED TO:

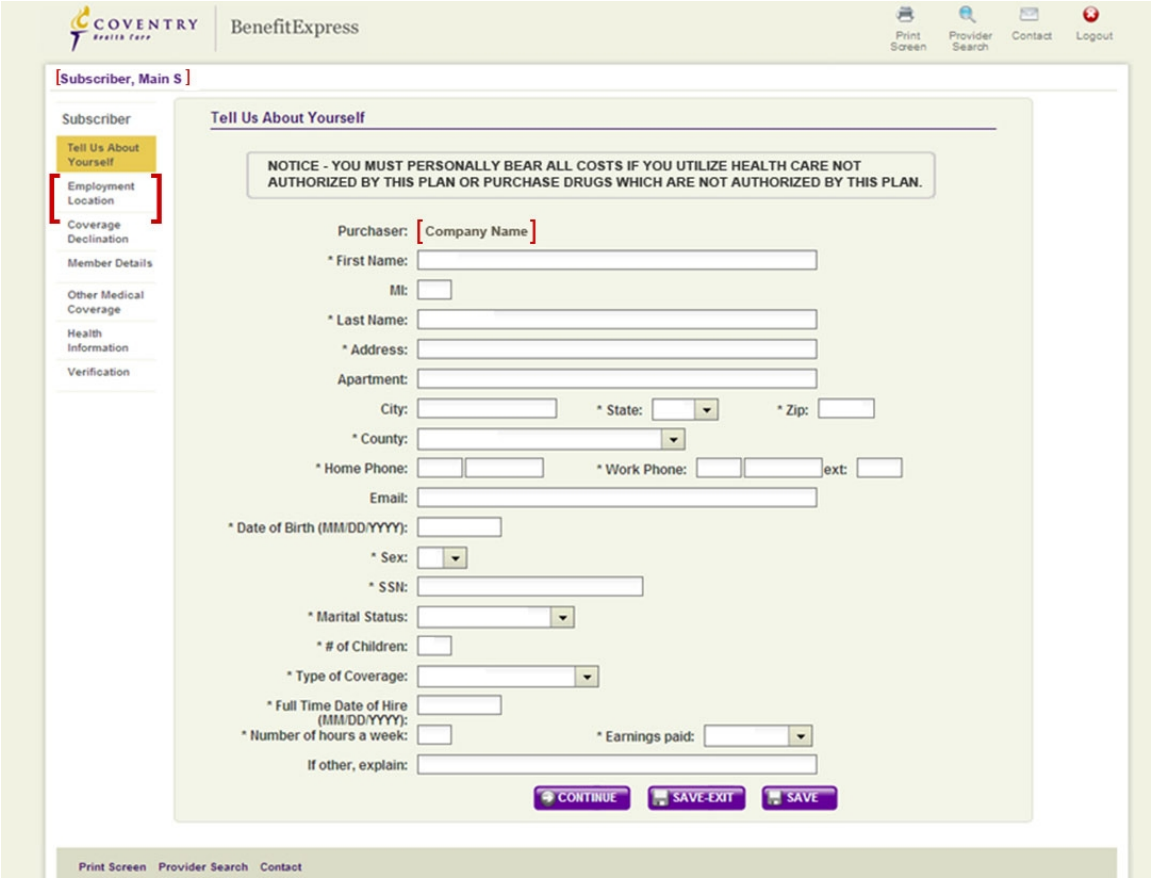
Signature:_____

Name:_____

Title:_____

Date:_____

Subscriber Enrollment: The system will move the user step by step through the enrollment screens. Any required fields which are missing information will be highlighted and an error message will be displayed at the top of the screen. The user is unable to navigate from the screen until all required information is completed.



The "State" drop down list contains the following:

State Drop Down List Contains:

AK	FL	KY	MS	NY	TN
AL	FM	LA	MT	OH	TX
AR	GA	MA	NA	OK	UT
AS	GU	MD	NC	OR	VA
AZ	HI	ME	ND	PA	VI
CA	IA	MH	NE	PR	VT
CO	ID	MI	NH	PW	WA
CT	IL	MN	NJ	RI	WI
DC	IN	MO	NM	SC	WV
DE	KS	MP	NV	SD	WY

The “County” drop down list contains all the contains represented by the states / territories listed above. A detailed list can be found in the embedded document.

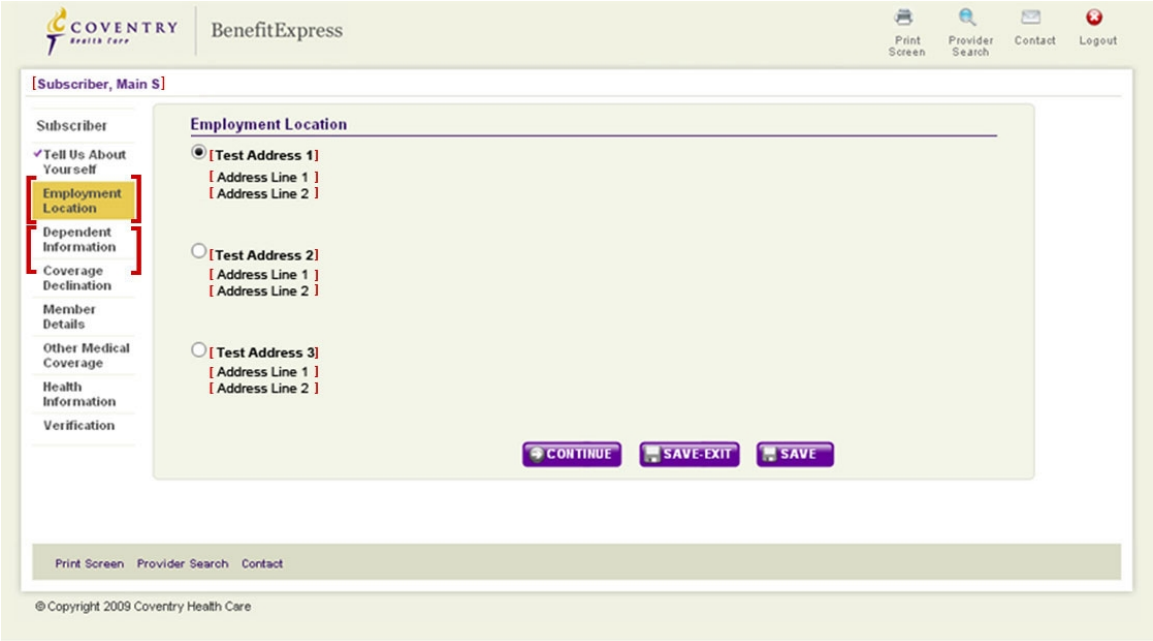
P:\E840\Standard App JPG\Standard Ap

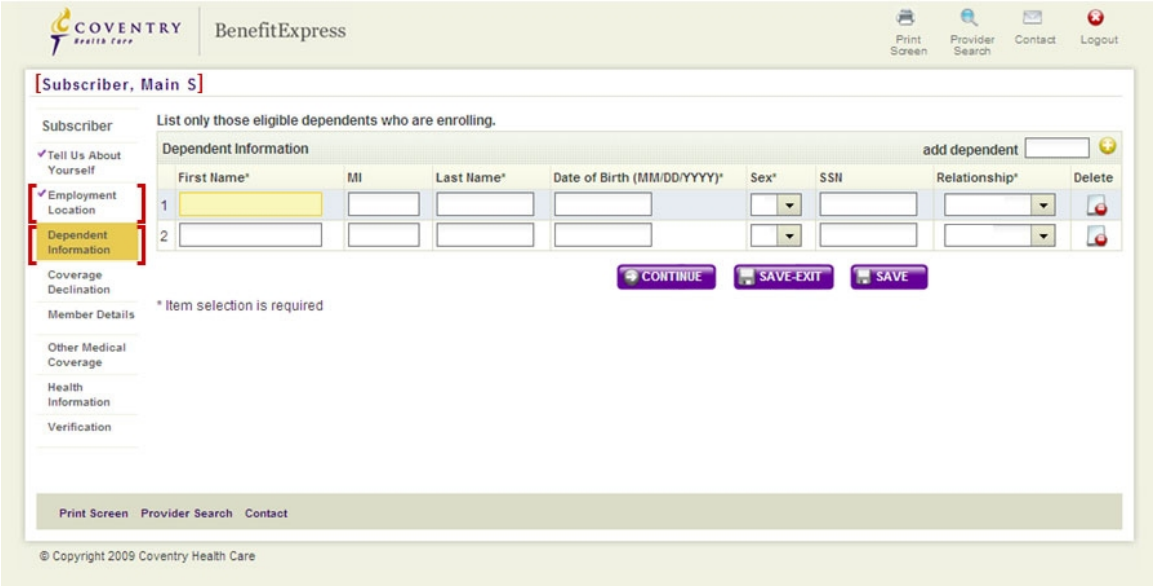
The “Sex” drop down list contains: M, F.

The “Marital Status” drop down list contains: Single/Widowed, Married, Divorced, Separated.

The “Type of Coverage” drop down list contains: Employee, Employee Spouse, Employee Child, Employee Children, Family, Waived.

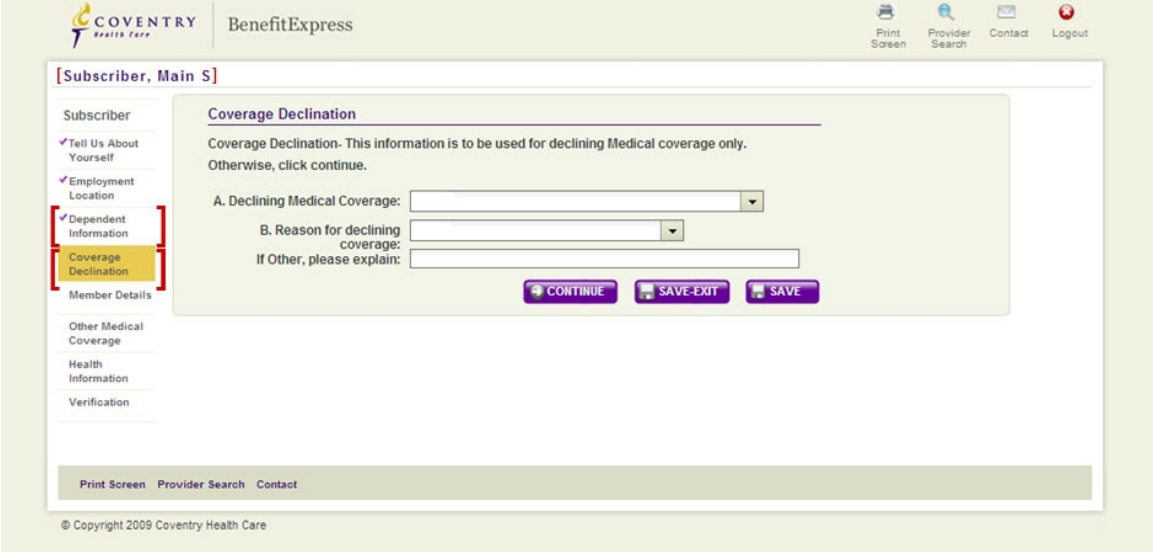
The “Earnings Paid” drop down list contains: Hourly, Salaried, Other.





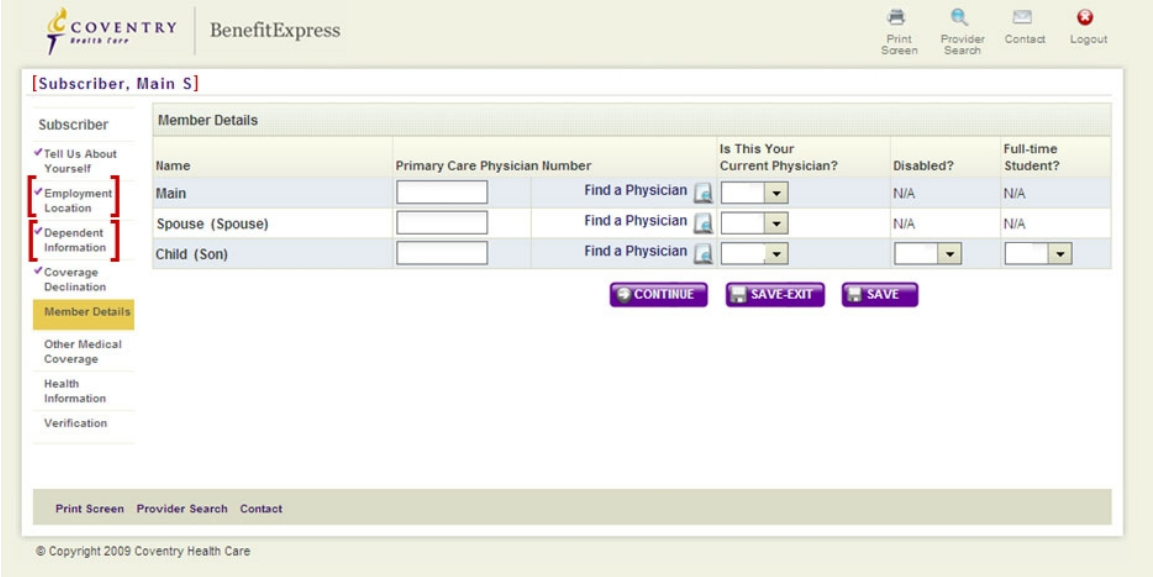
The “Sex” drop down list contains: M, F.

The “Relationship” drop down list contains: Spouse, Son, Daughter.



The “Declining Medical Coverage” drop down list contains: None, Myself (Includes spouse and dependents), Spouse.

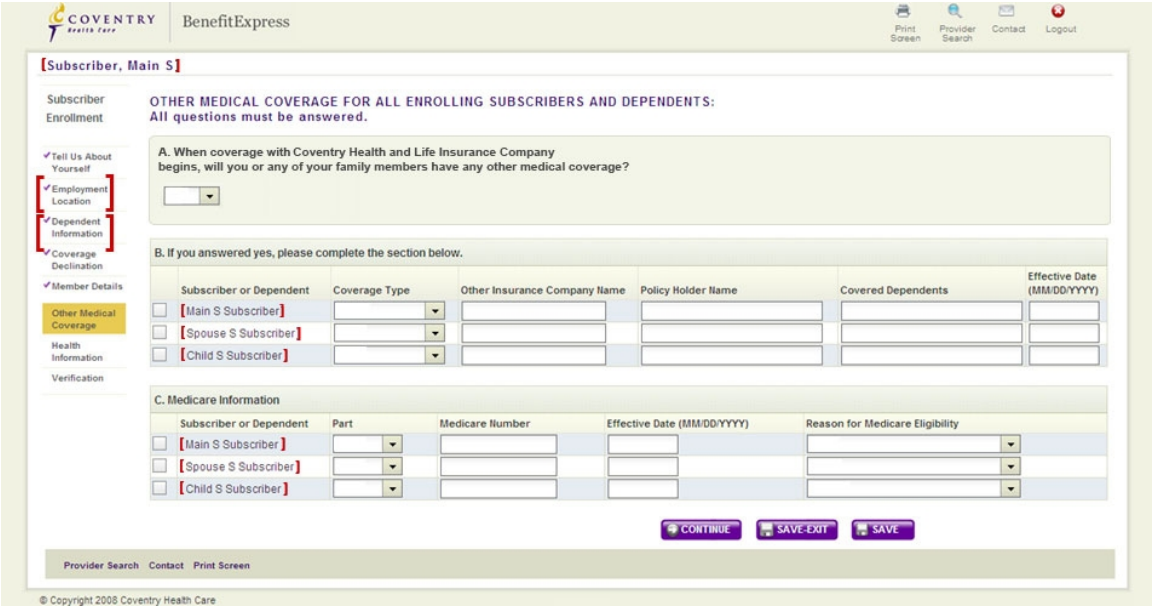
The “Reason for declining coverage” drop down list contains: N/A, Other health coverage, Spousal coverage, Other reason (please explain).



The “Is This Your Current Physician” drop down list contains: No, Yes.

The “Disabled” drop down list contains: No, Yes.

The “Full-time Student” drop down list contains: No, Yes.

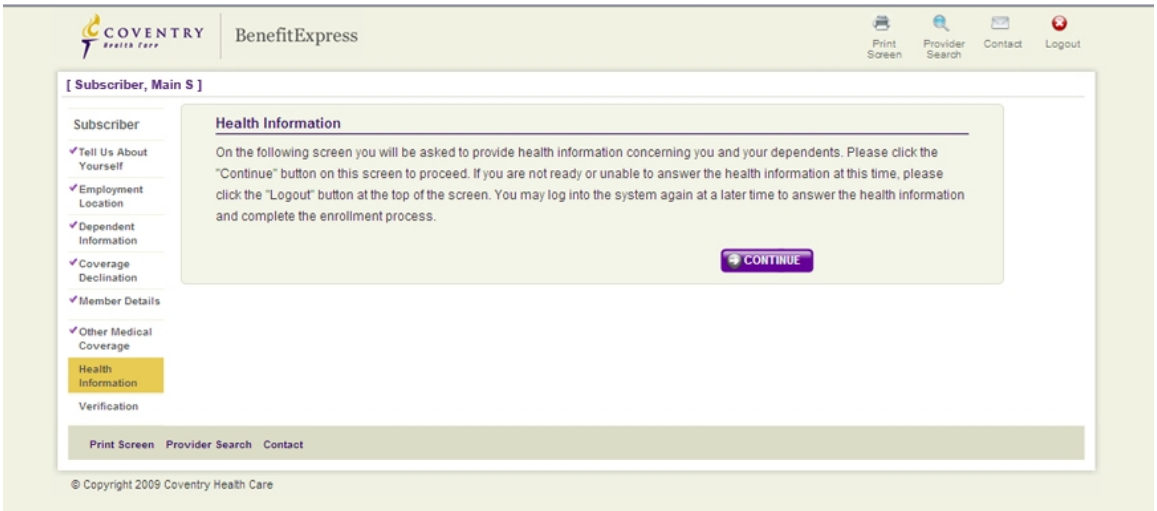


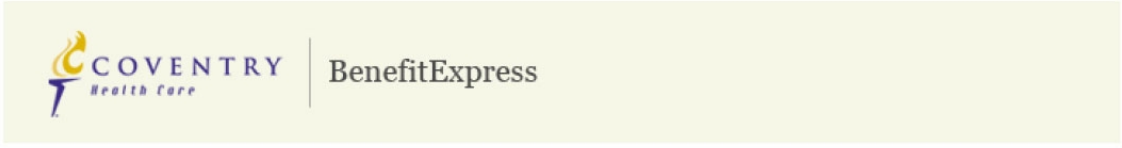
The Question “A. When coverage with” drop down list contains: No, Yes, Unknown.

The “Coverage Type” drop down list contains: None, Group Policy, Individual Policy, Medicare, Pharmacy, Group Policy + Pharmacy, Medicaid, Tricare, Other.

The “Part” drop down list contains: None, A, B, C, D, A & B, A & D, B & D.

The “Reason for Medicare Eligibility” drop down list contains: None, Over 65, Kidney Disease (ESRD), Disabled, ALS (Lou Gehrig’s disease), Retired.





Have you or any family member listed on this form consulted with, received advice from or been examined, diagnosed or treated by any health care professional during the last five (5) years for any illness, injury or health condition in any of the categories listed below? If “YES,” please check the box that most appropriately describes the problem and explain fully below.

In completing this form and answering the questions set forth herein, you should not include any of your and/or your dependent’s family history or genetic information (including, but not limited to, genetic testing, genetic services, genetic counseling, or genetic diseases for which you and/or your dependents may be at risk).

By submitting this application, you understand the purpose of the disclosure and use of your information is to allow Coventry Health and Life Insurance Company to make decisions regarding eligibility, enrollment, underwriting and premium risk rating.

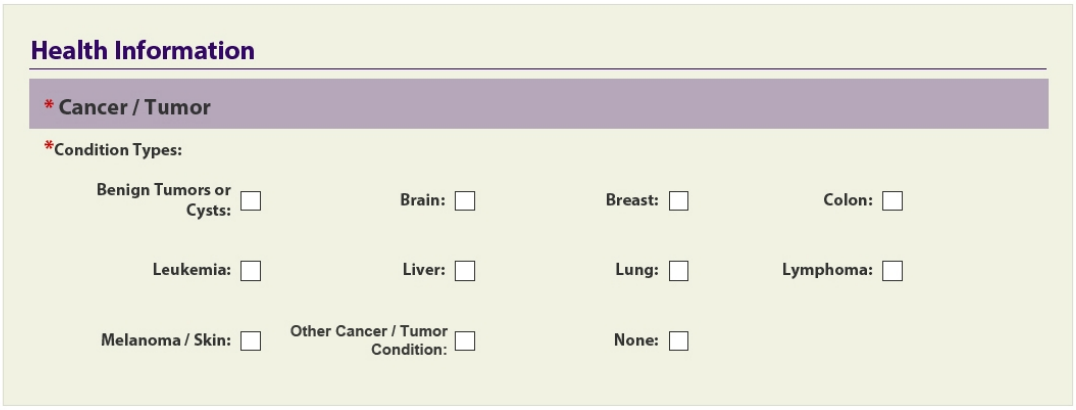
Please note: If you leave out or misrepresent material information on this form, we may rescind, terminate, or modify your coverage or your premium.

Height and Weight

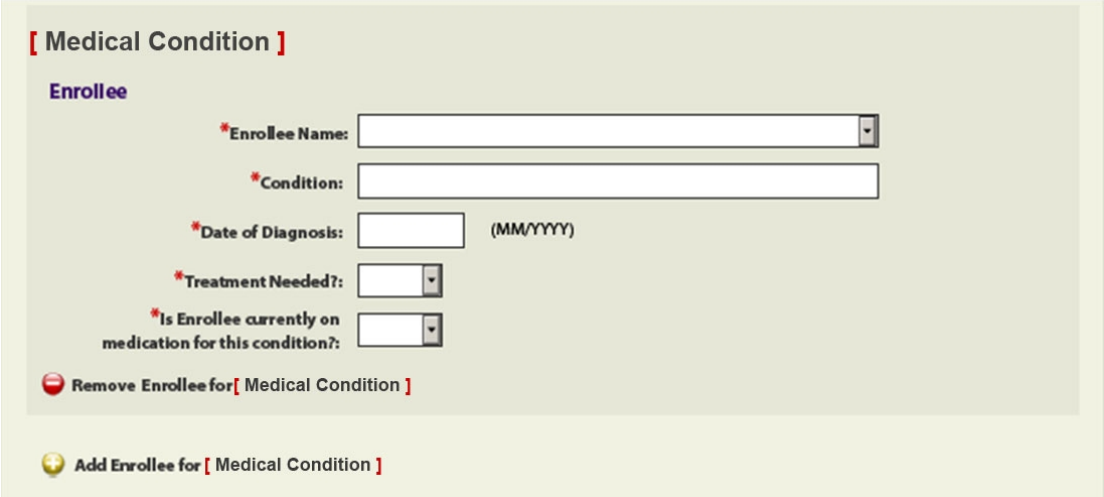
Name	*Height	*Weight
[Main S Subscriber,]	(ft) (in)	(lbs)

The “Height” (ft) drop down list contains: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9.

The “Height” (in) drop down list contains: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11.



If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

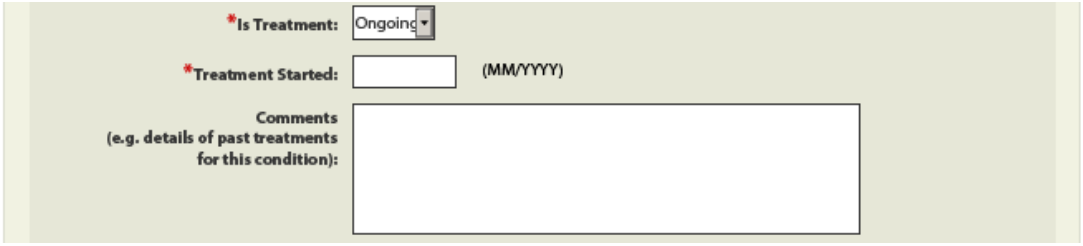
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

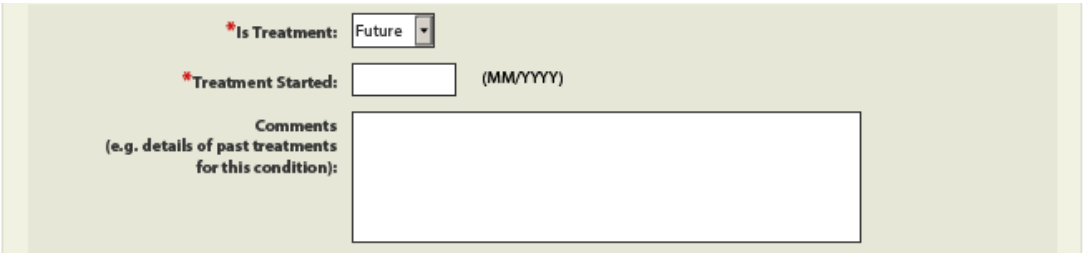
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

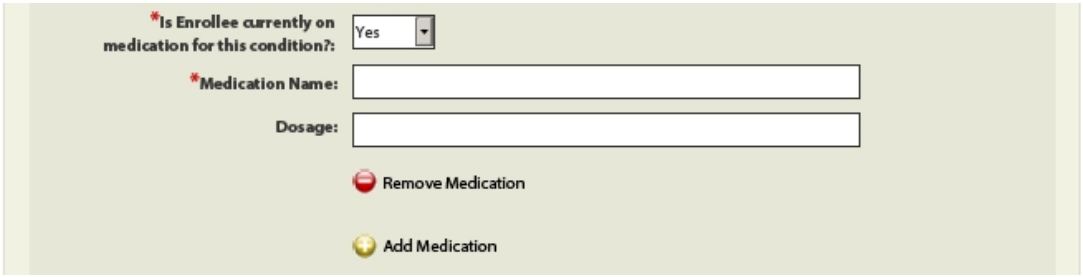
If they select “Ongoing”, the following screen will display.

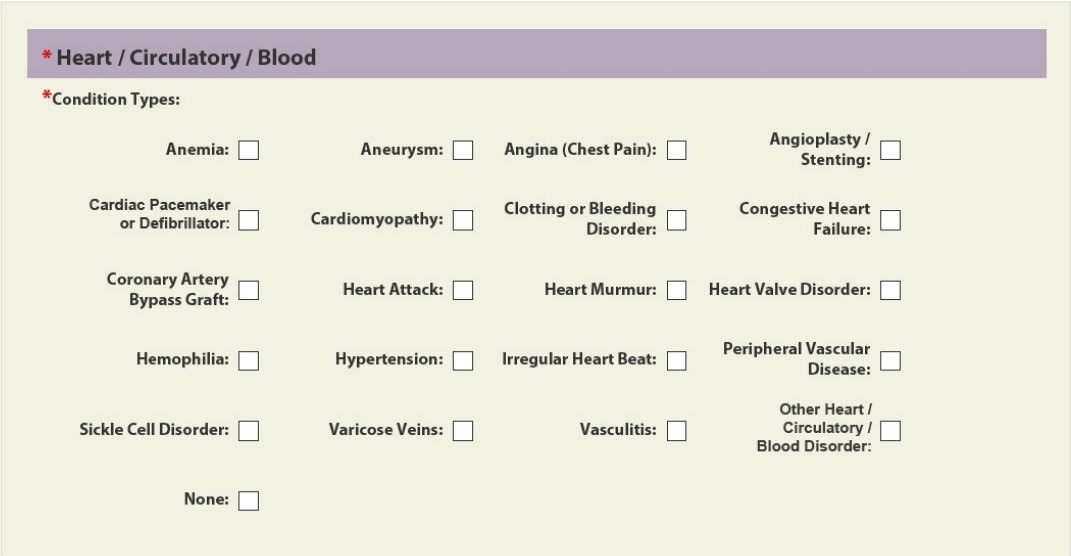


If they select “Future”, the following screen will display.

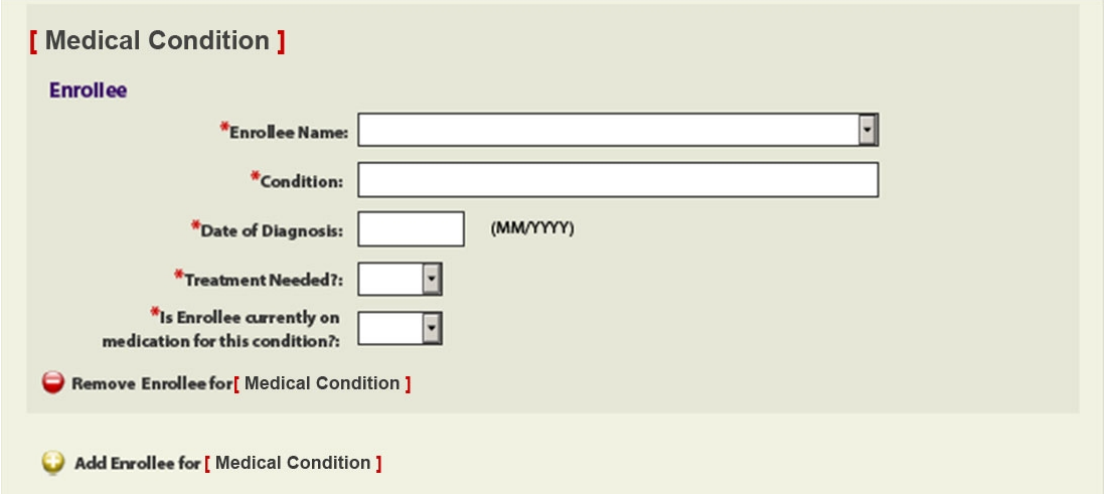


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.





If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

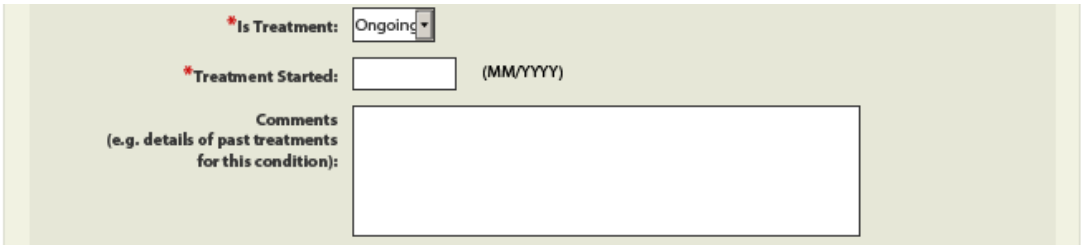
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

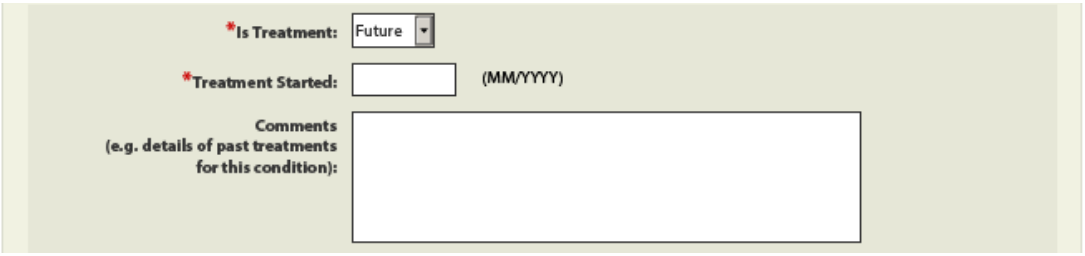
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

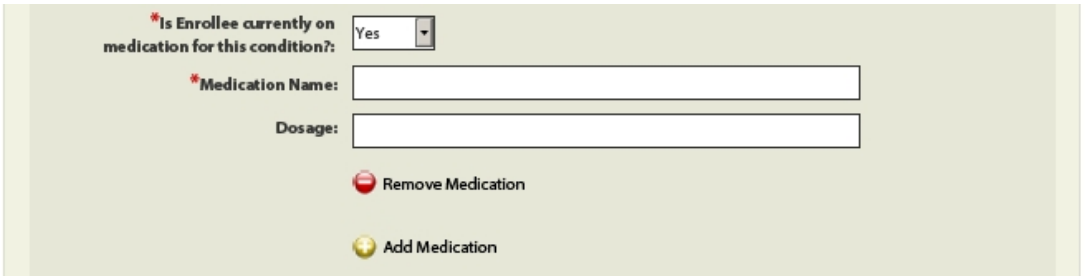
If they select “Ongoing”, the following screen will display.

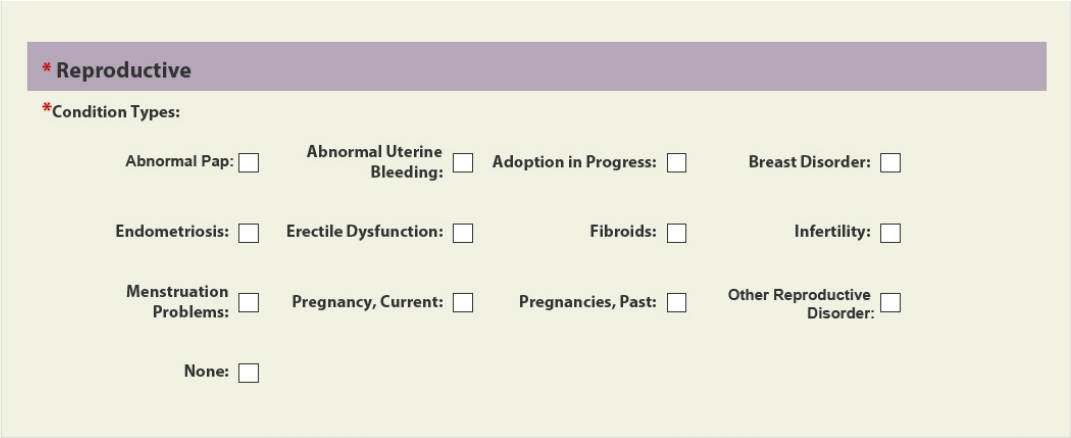


If they select “Future”, the following screen will display.

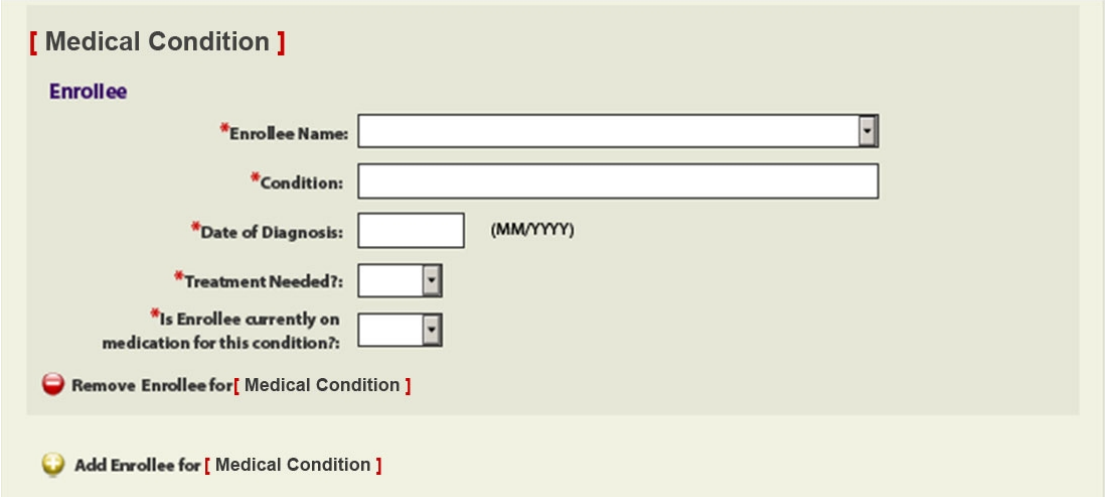


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.





If the subscriber selects a condition other than “Pregnancy, Current”, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

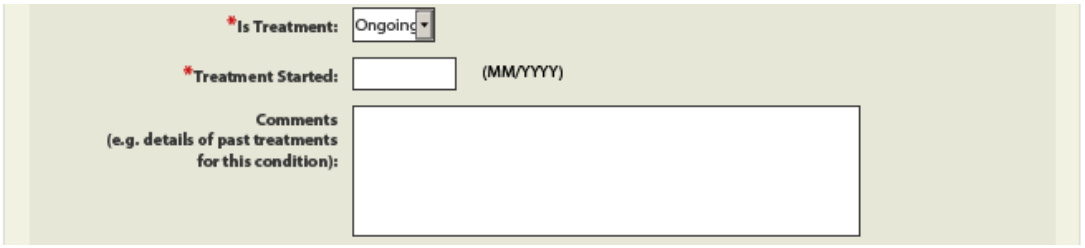
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

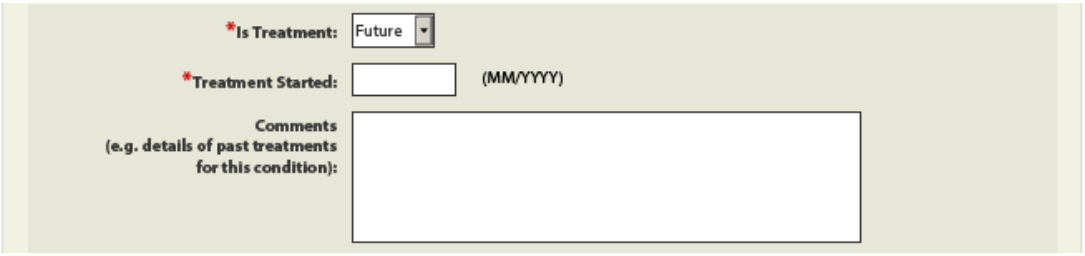
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

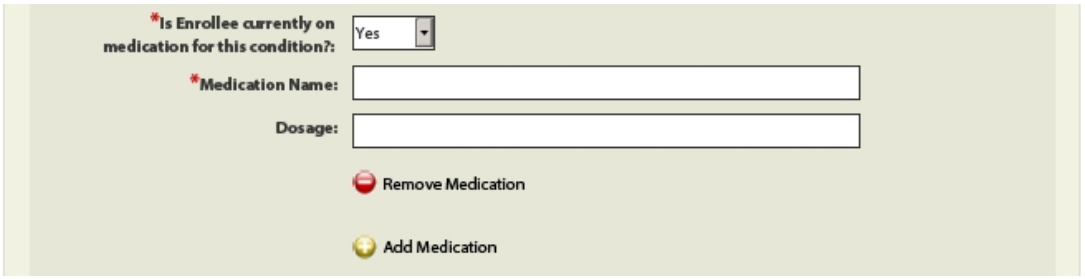
If they select “Ongoing”, the following screen will display.



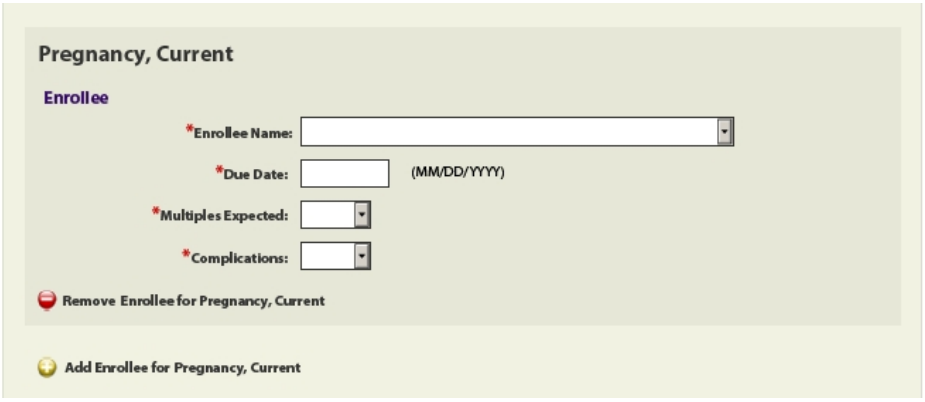
If they select “Future”, the following screen will display.



If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.



If the subscriber selects “Pregnancy, Current”, they will be asked the following questions:

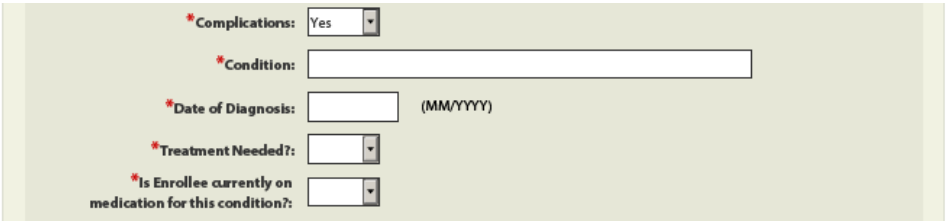


The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

The “Multiples Expected” drop down list contains: No, Yes.

The “Complications” drop down list contains: No, Yes.

If the subscriber answers “Yes” to “Complications”, they are asked to provide the following details:



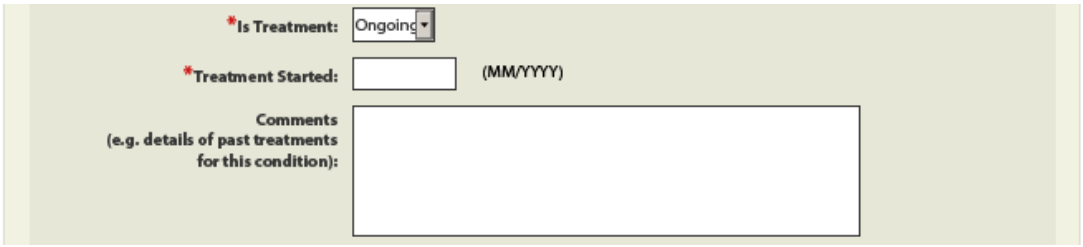
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

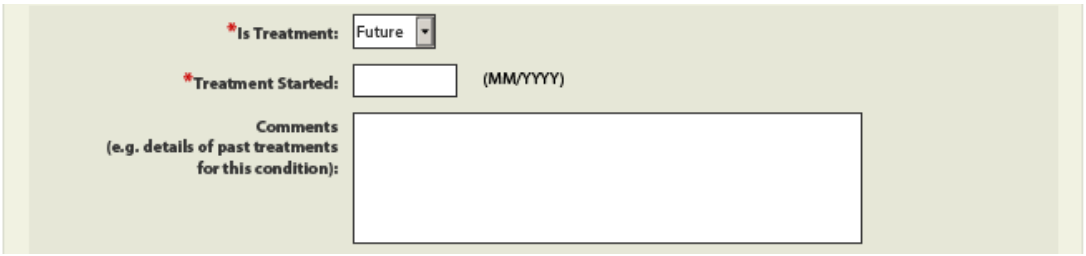
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

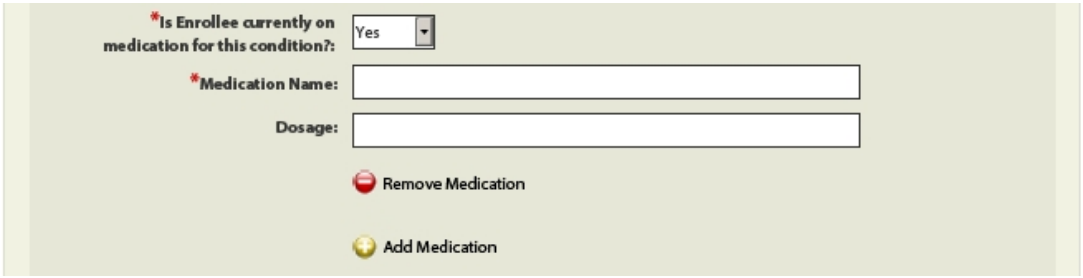
If they select “Ongoing”, the following screen will display.

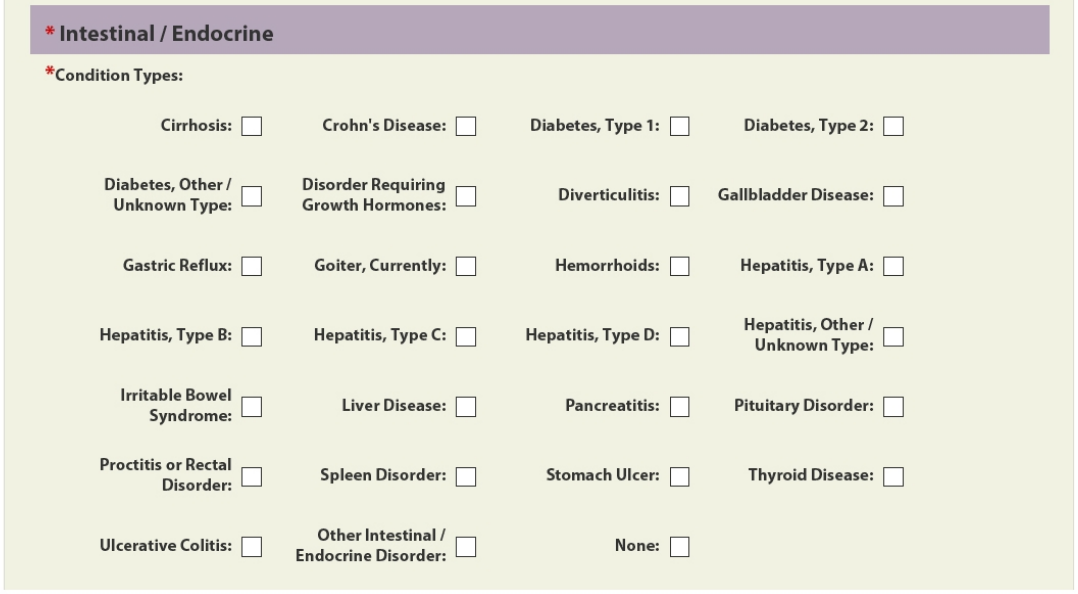


If they select “Future”, the following screen will display.

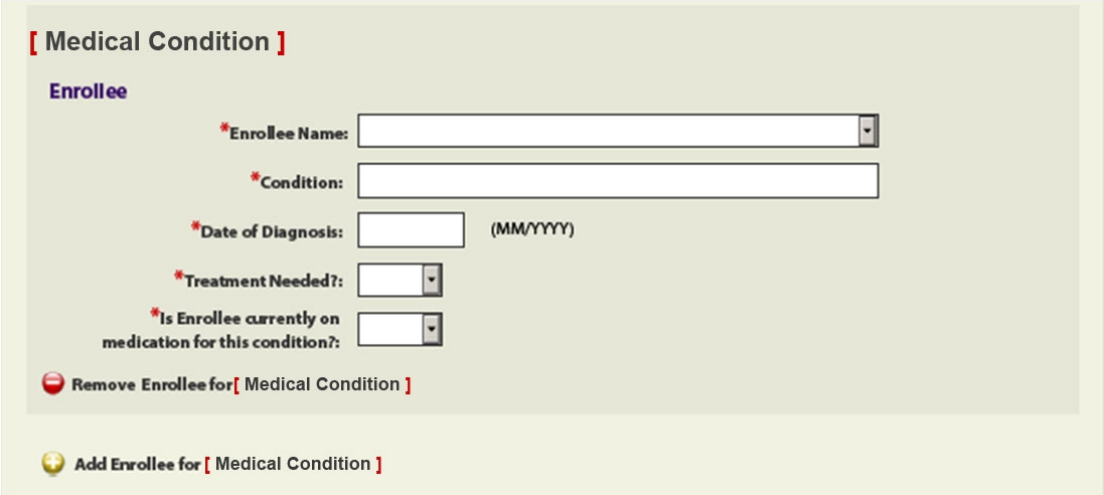


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.





If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

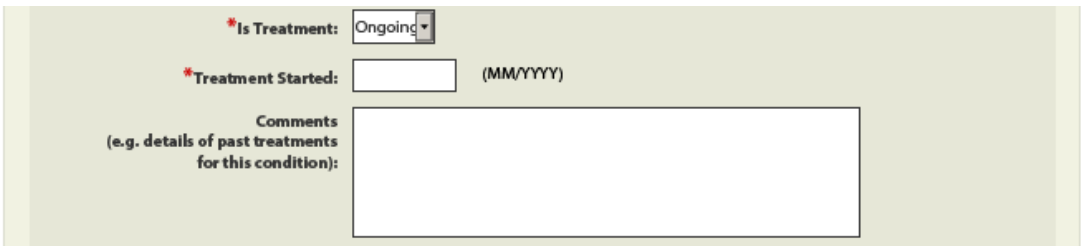
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

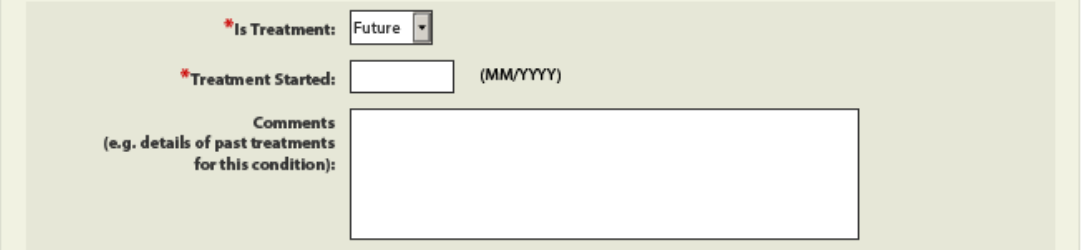
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

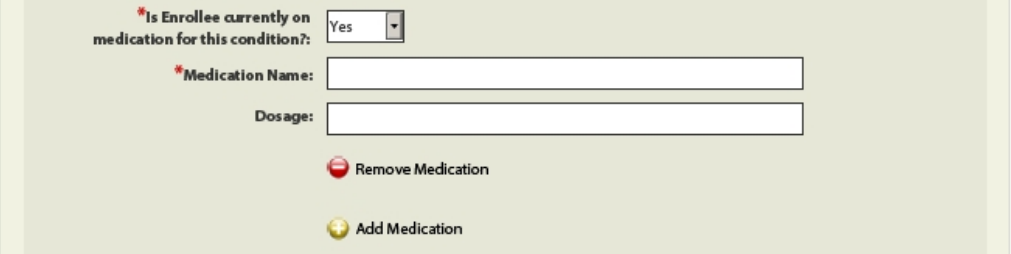
If they select “Ongoing”, the following screen will display.

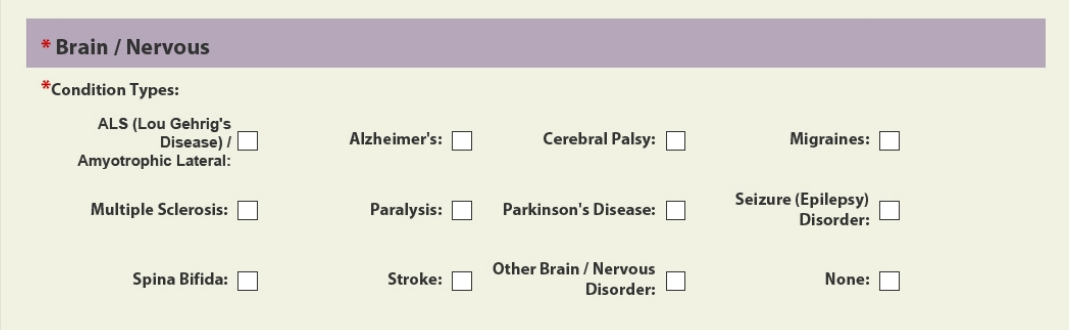


If they select “Future”, the following screen will display.

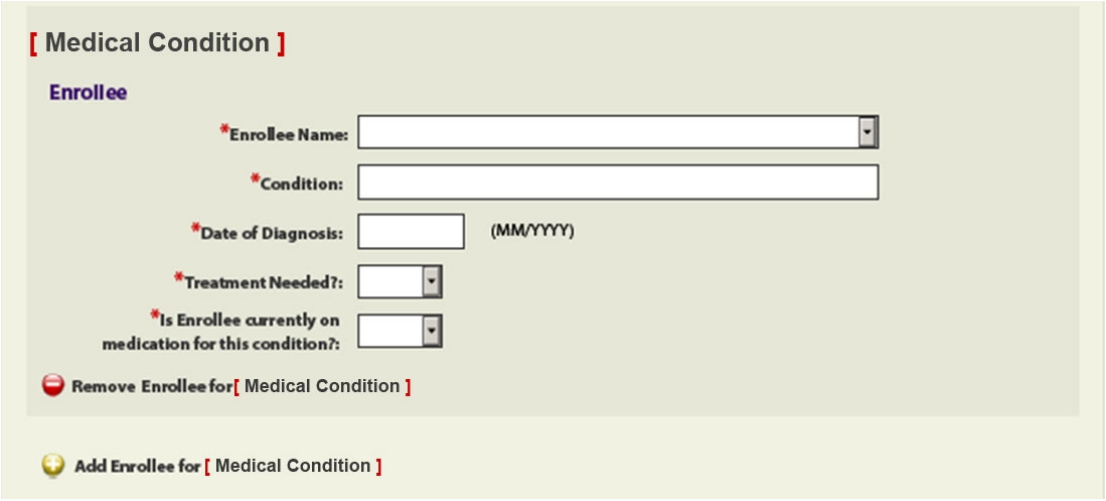


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.





If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

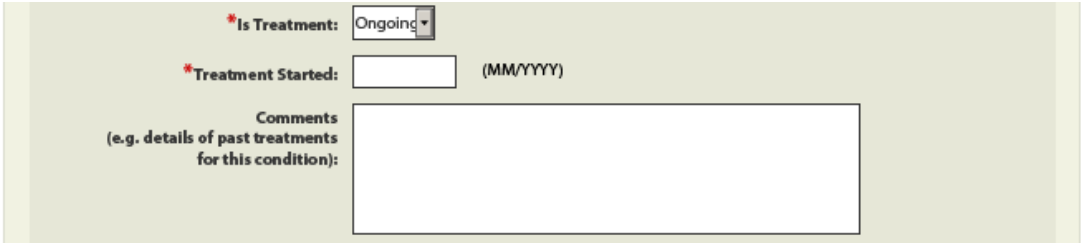
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

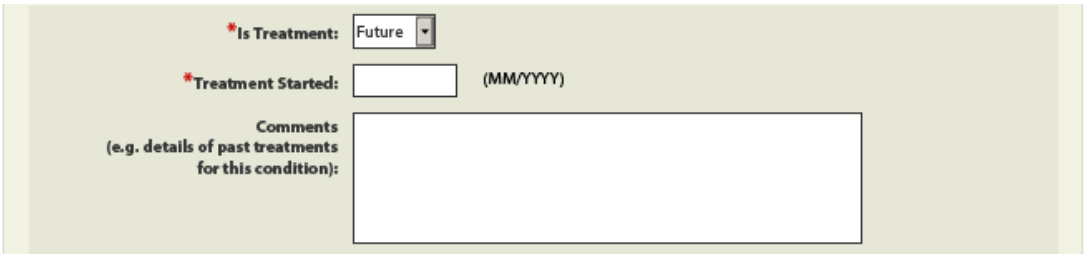
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

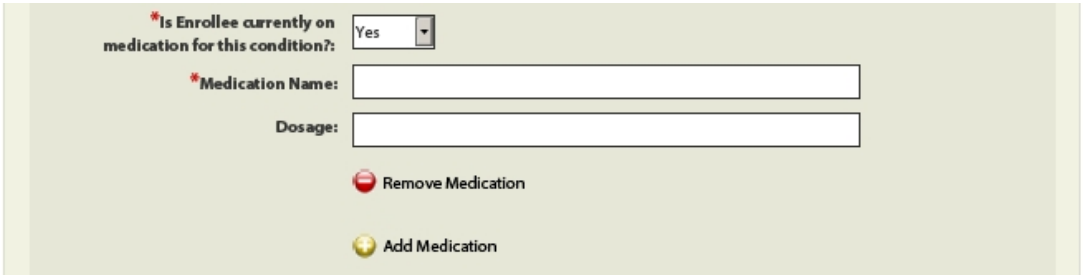
If they select “Ongoing”, the following screen will display.

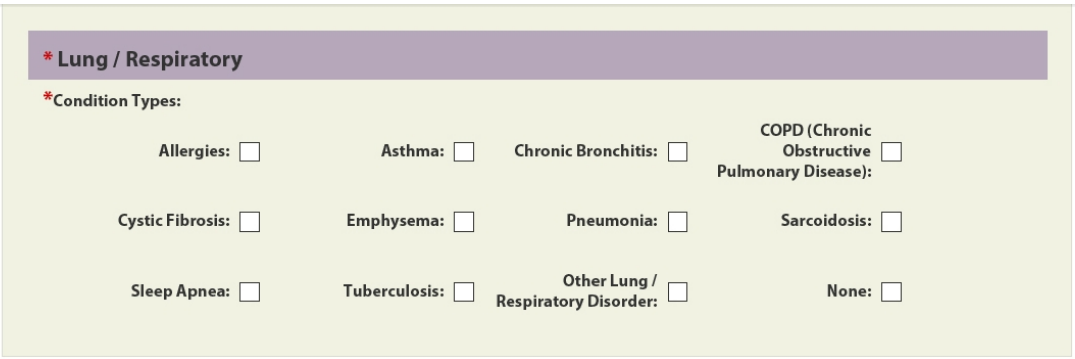


If they select “Future”, the following screen will display.

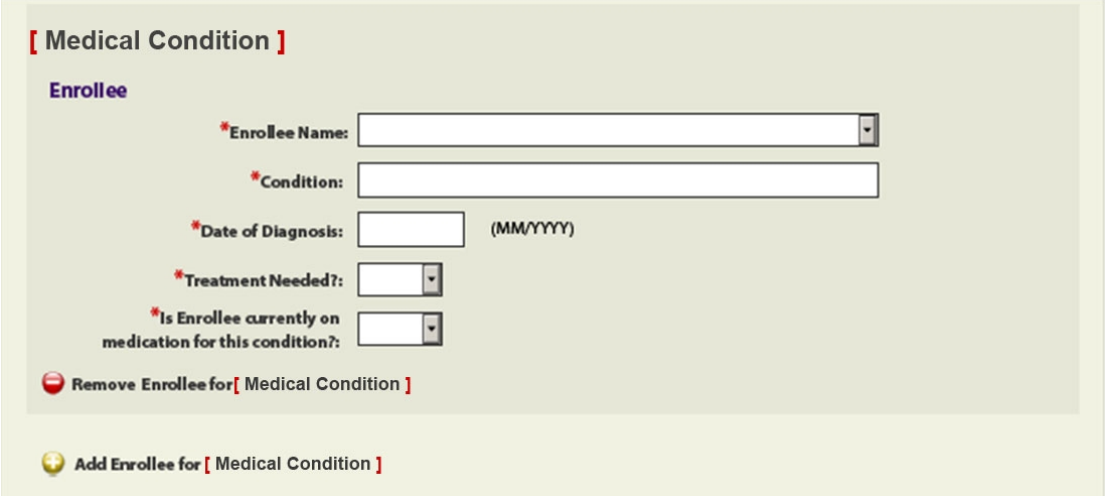


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.





If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

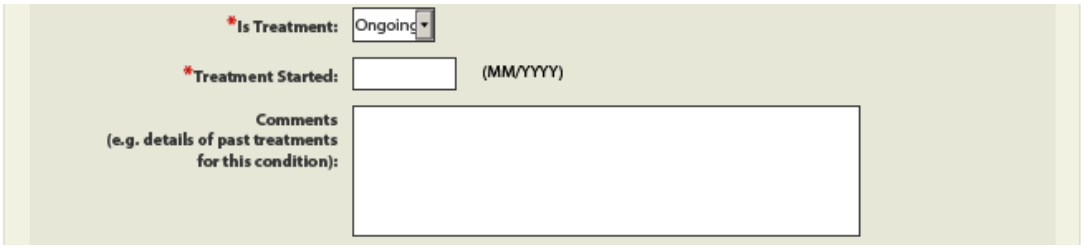
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

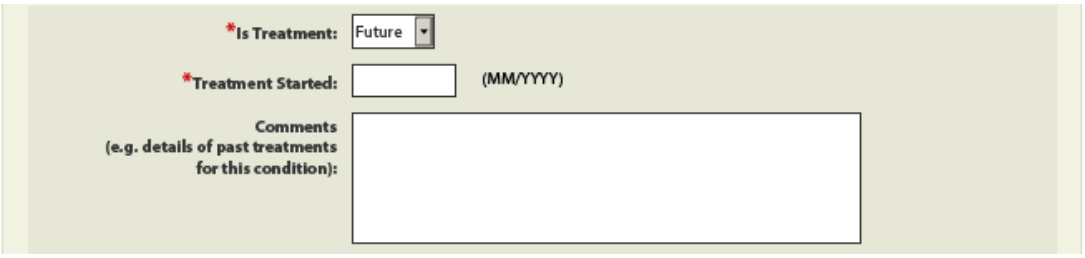
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

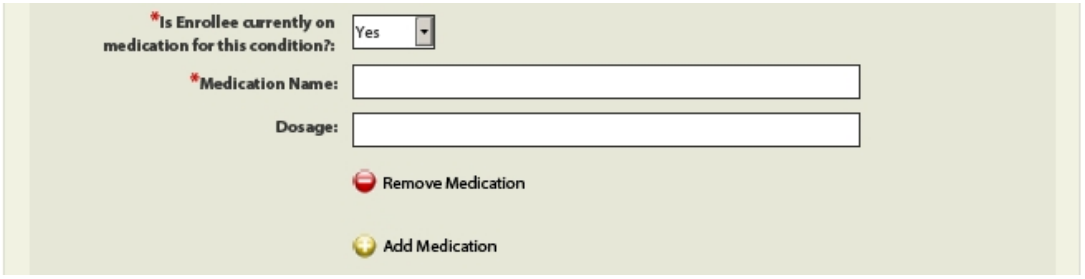
If they select “Ongoing”, the following screen will display.

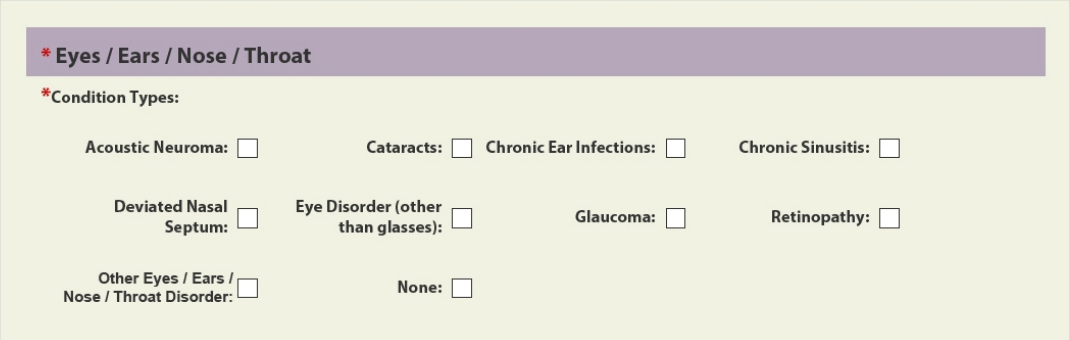


If they select “Future”, the following screen will display.

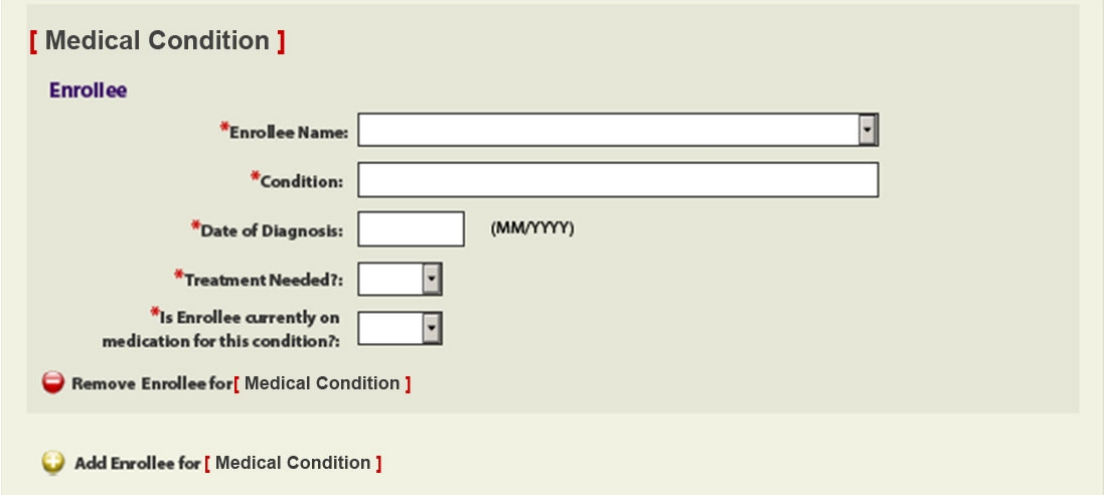


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.





If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

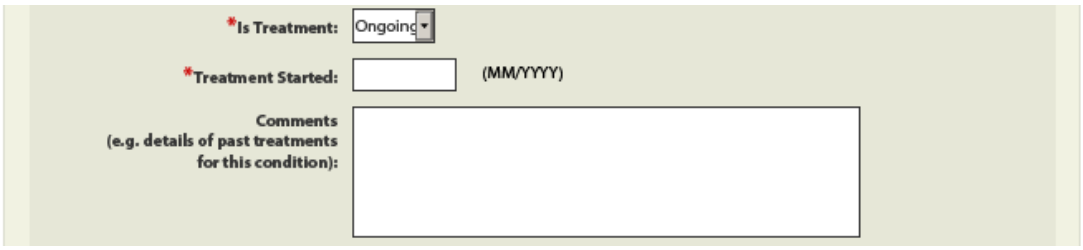
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

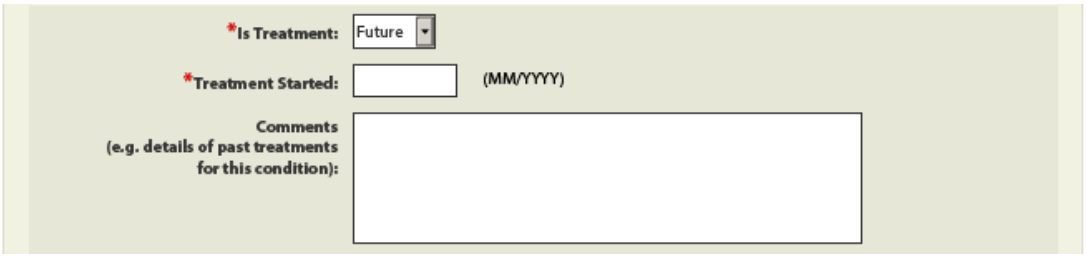
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

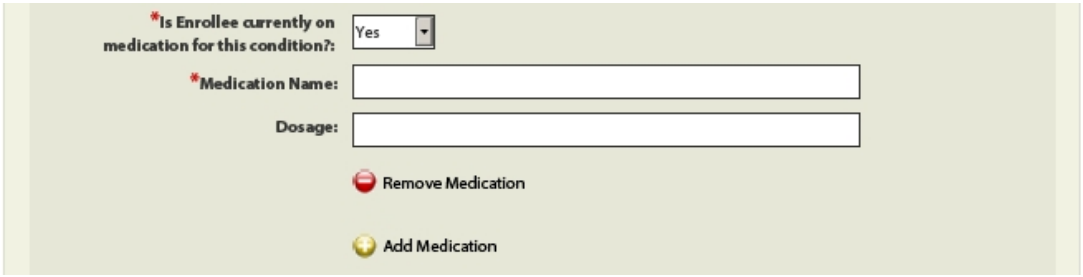
If they select “Ongoing”, the following screen will display.

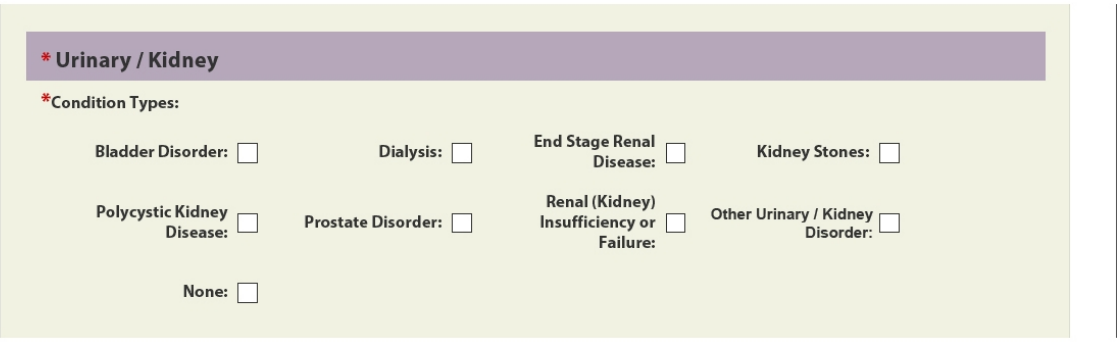


If they select “Future”, the following screen will display.

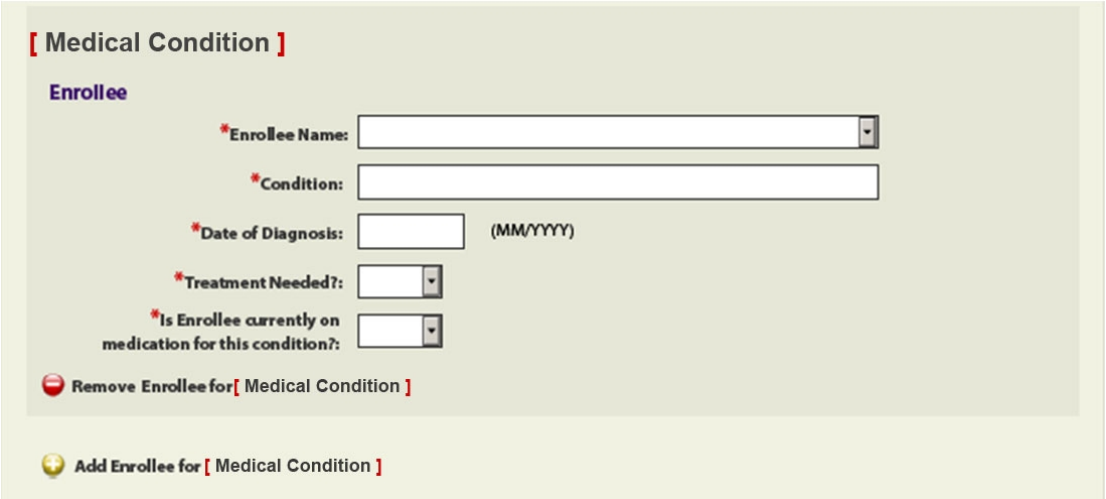


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.





If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

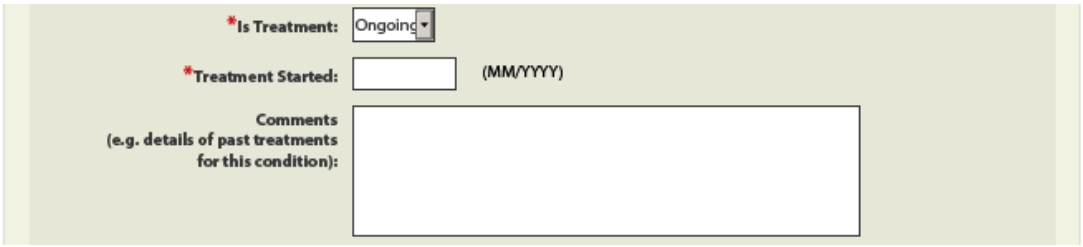
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

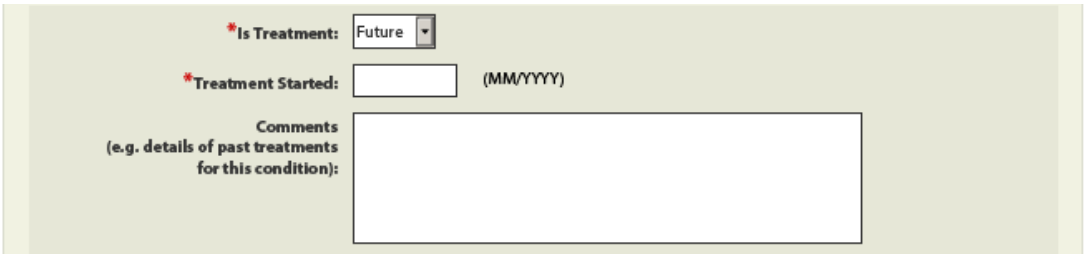
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

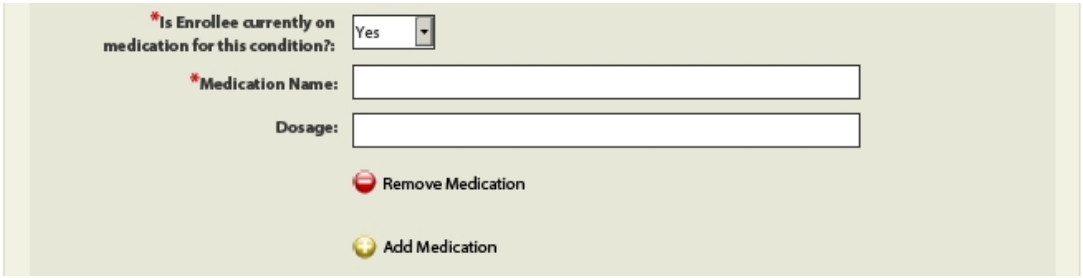
If they select “Ongoing”, the following screen will display.

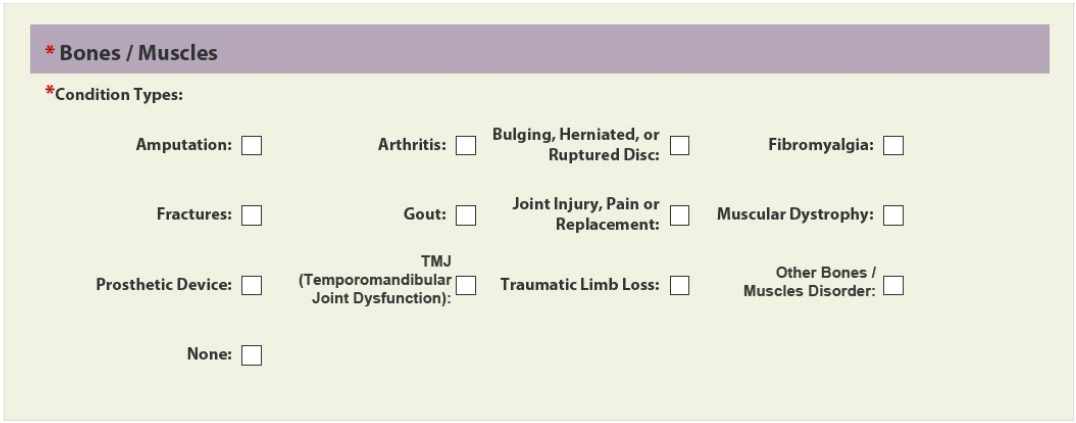


If they select “Future”, the following screen will display.

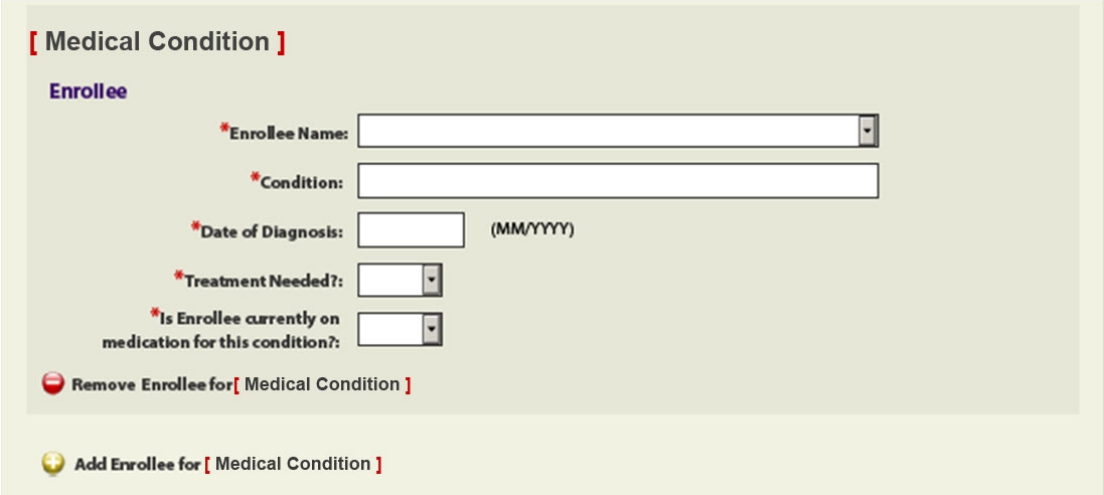


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.





If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

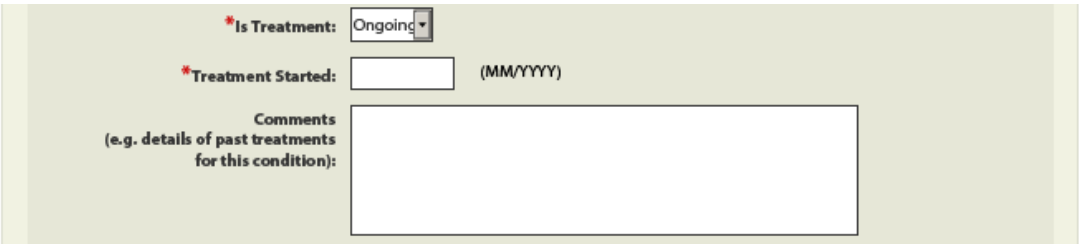
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

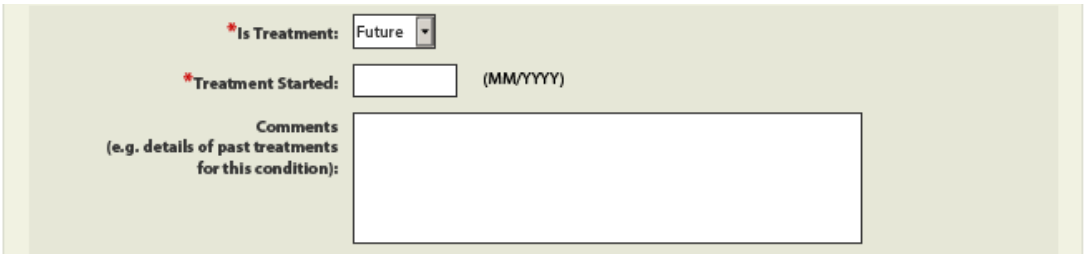
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

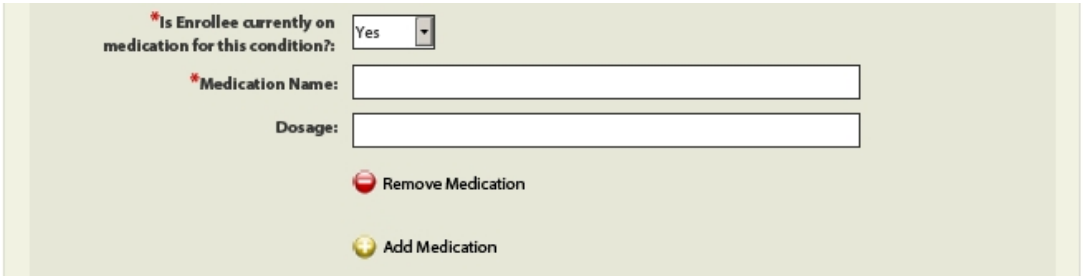
If they select “Ongoing”, the following screen will display.



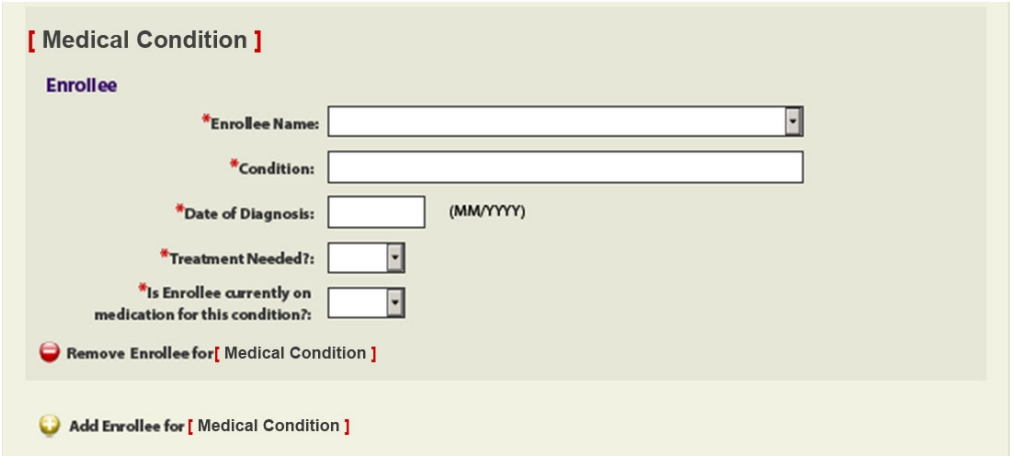
If they select “Future”, the following screen will display.



If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.



If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

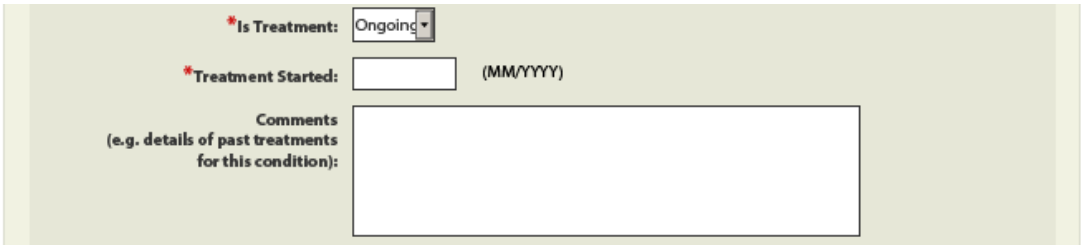
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

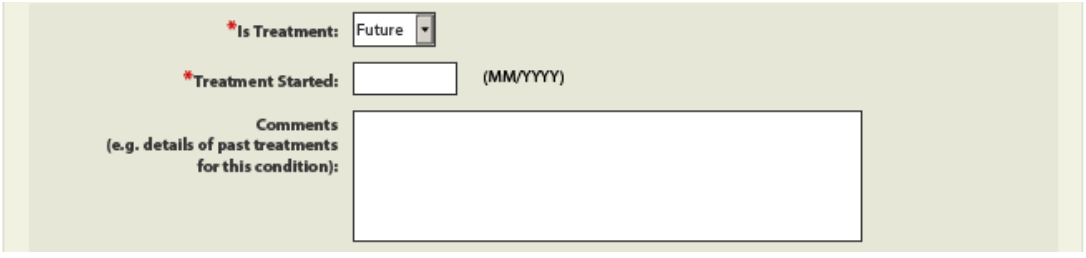
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

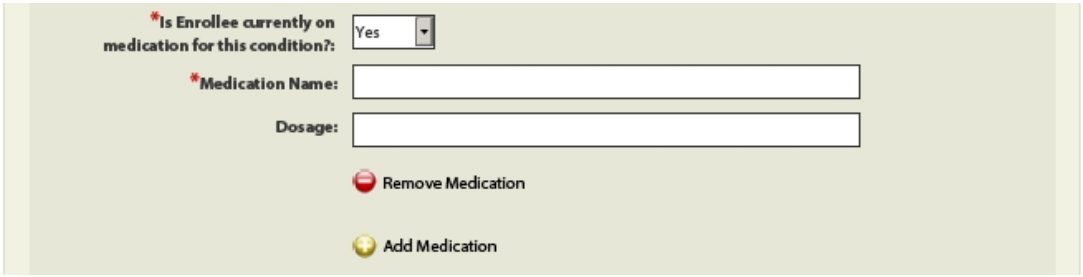
If they select “Ongoing”, the following screen will display.

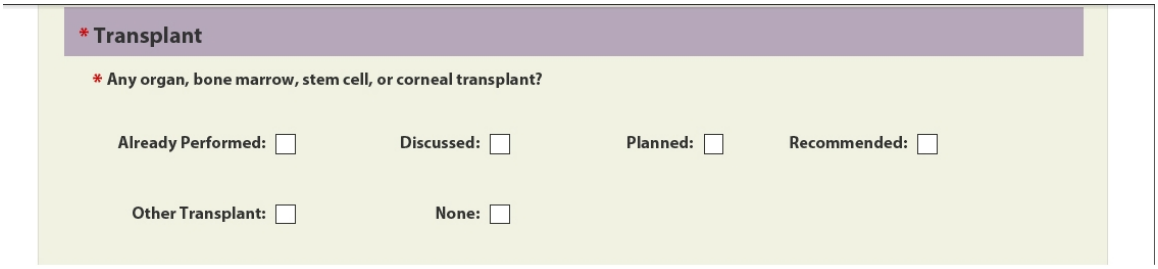


If they select “Future”, the following screen will display.

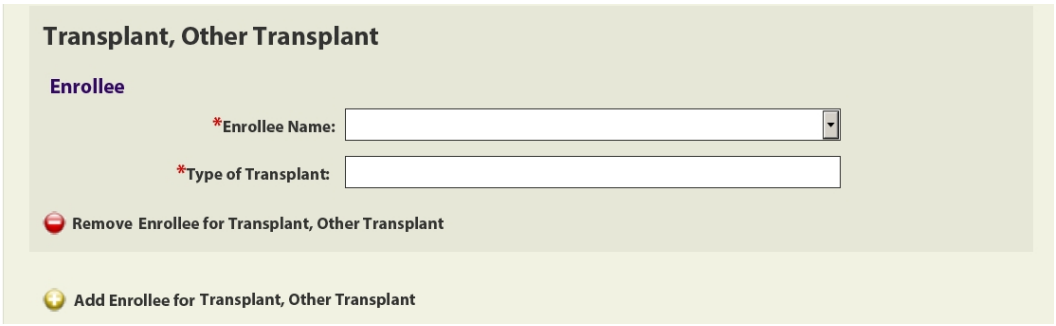


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.

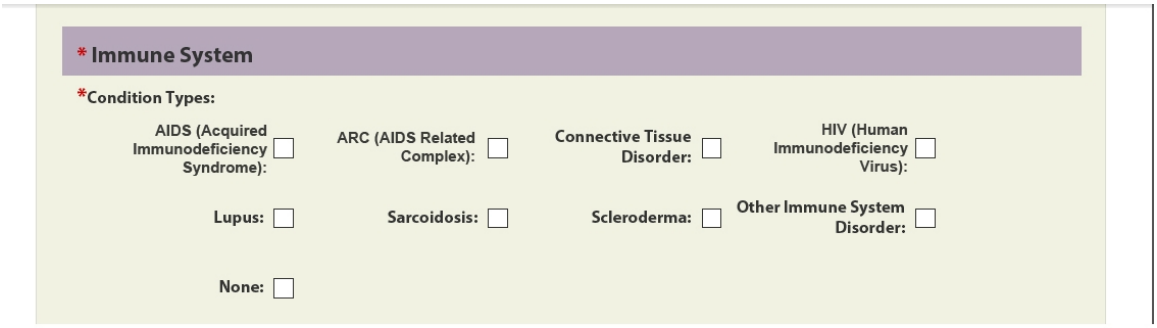




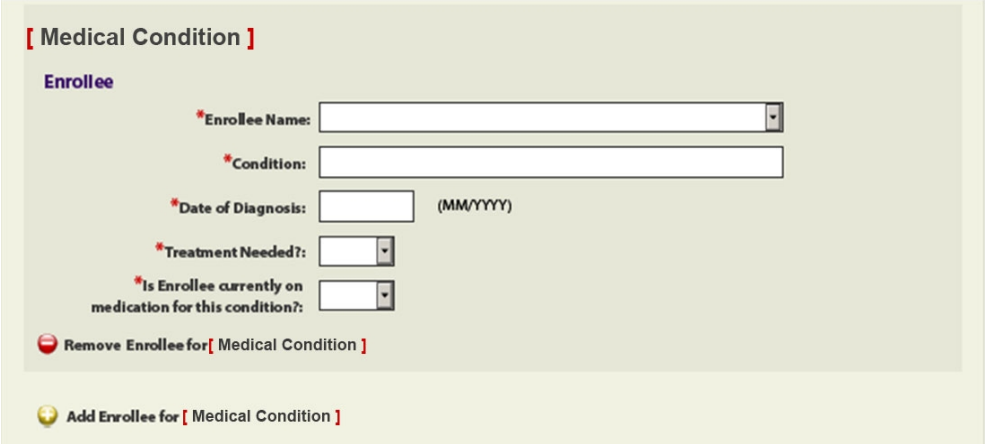
If the subscriber makes a selection other than “None”, they will be asked to provide additional details.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.



If the subscriber selects a condition, they will be asked to provide additional details related to that condition.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

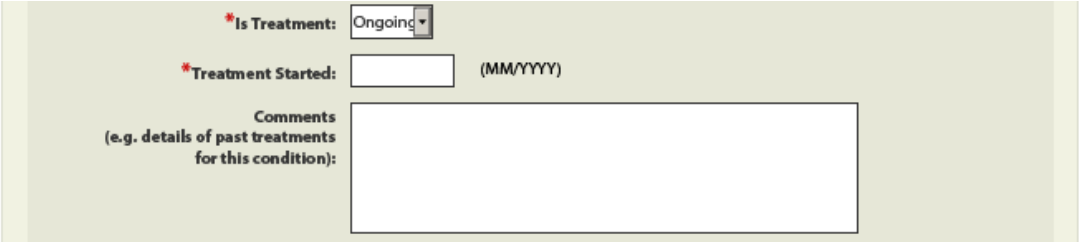
The “Treatment Needed” drop down list contains: No, Yes.

The “Is Enrollee currently on medication for this condition” drop down list contains: No, Yes.

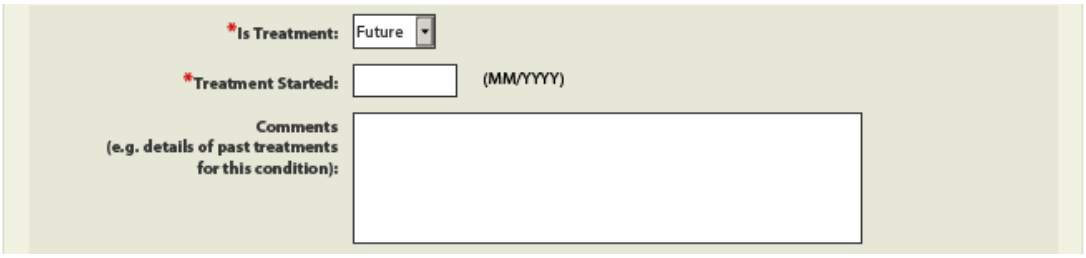
If the subscriber answers “Yes” to “Treatment Needed?”, they are asked “Is Treatment”. The “Is Treatment” drop down list contains: Past, Ongoing, Future.

If they select “Past”, the following screen will display.

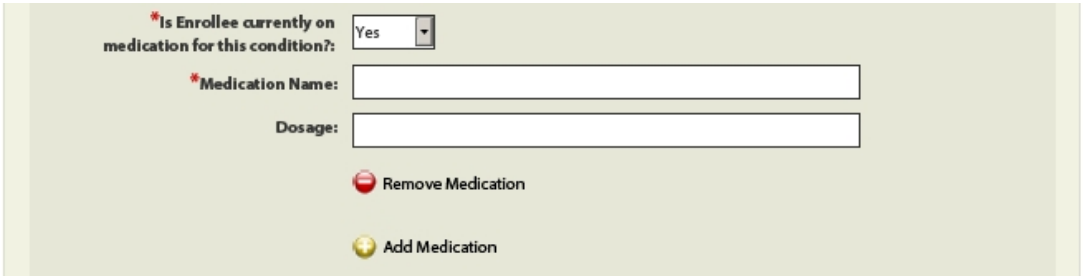
If they select “Ongoing”, the following screen will display.

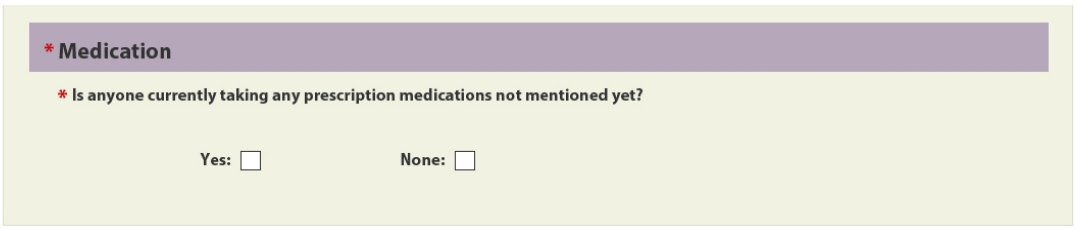


If they select “Future”, the following screen will display.

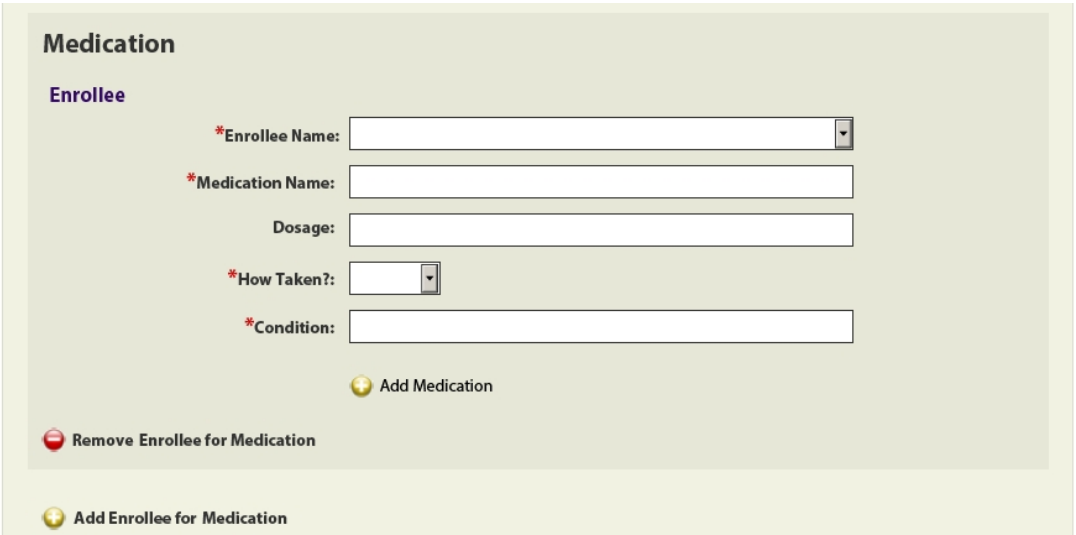


If the subscriber answers “Yes” that they are currently on medication for the condition, the following details are asked.



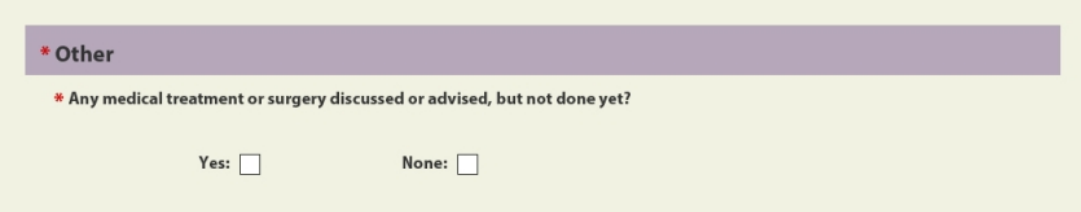


If the subscriber selects “Yes”, they will be asked to provide additional details on the medication.

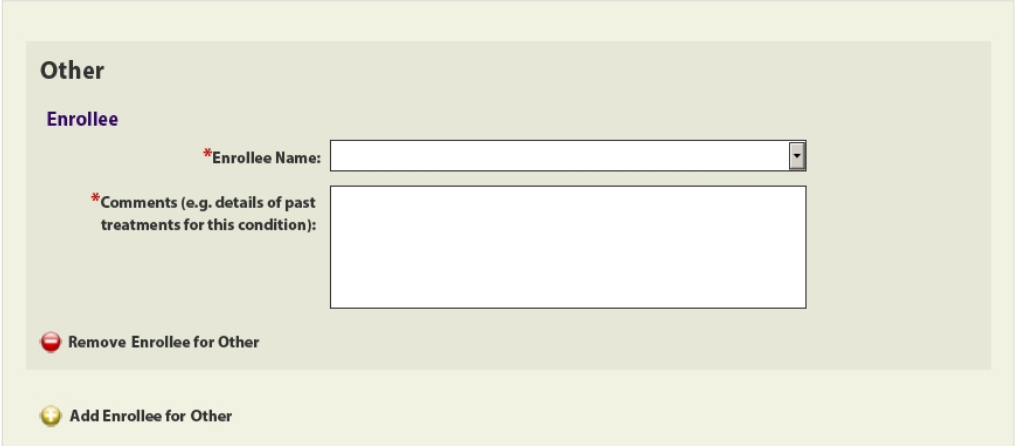


The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

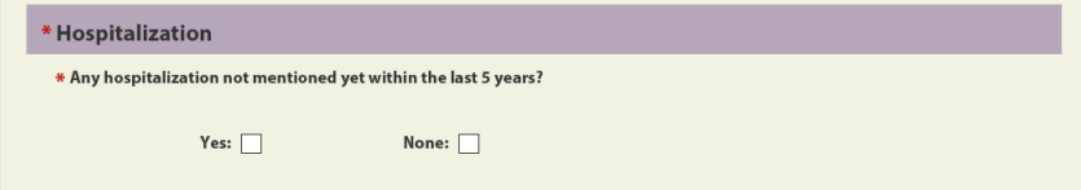
The “How Taken” drop down list contains: Infused, Inhaled, Injectable, Oral.



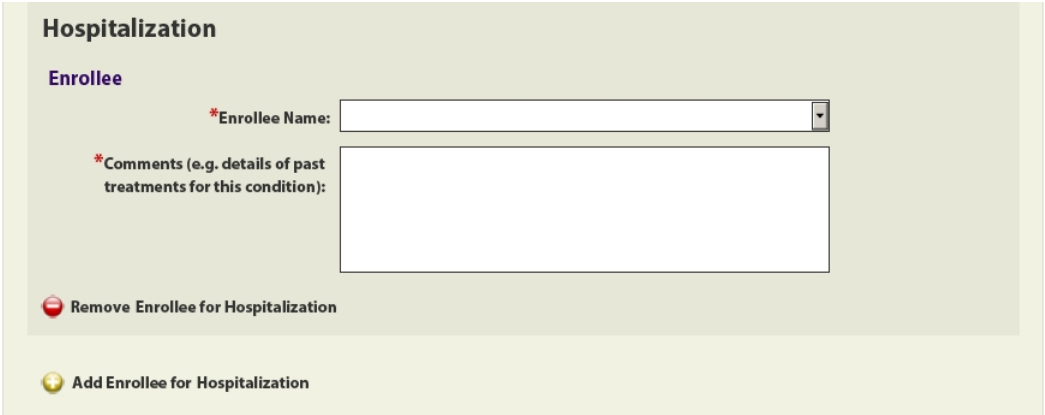
If the subscriber answers “Yes” that they have medical treatment or surgery discussed or advised, but not done yet, the following details are asked.



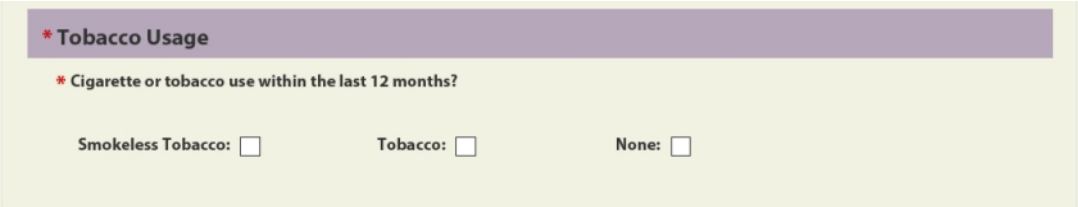
The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.



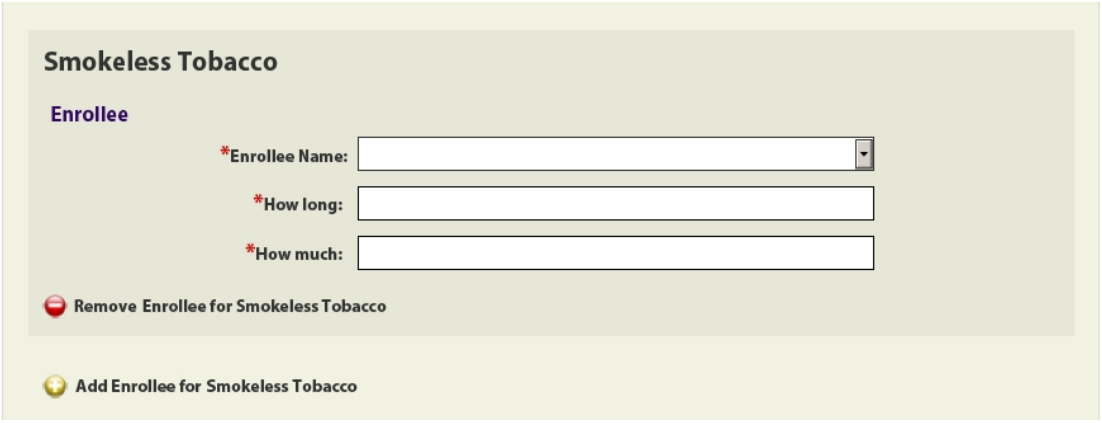
If the subscriber selects “Yes”, they will be asked to provide additional details on the hospitalization.



The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

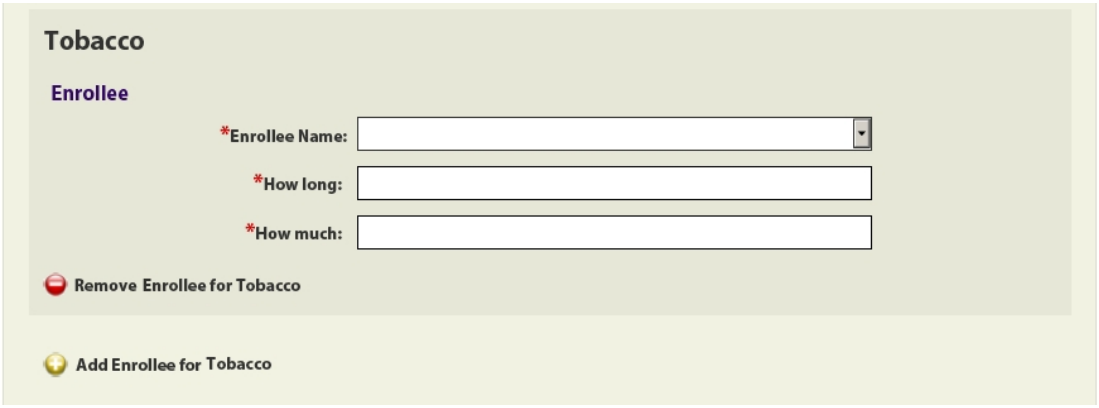


If the subscriber selects “Smokeless Tobacco”, they will be asked to provide additional details on the smokeless tobacco usage.



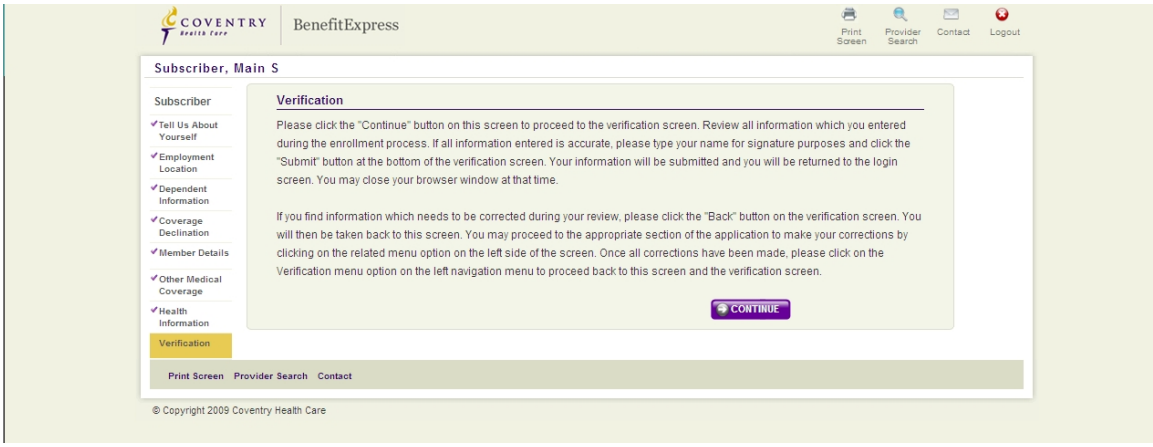
The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

If the subscriber selects “Tobacco”, they will be asked to provide additional details on the tobacco usage.

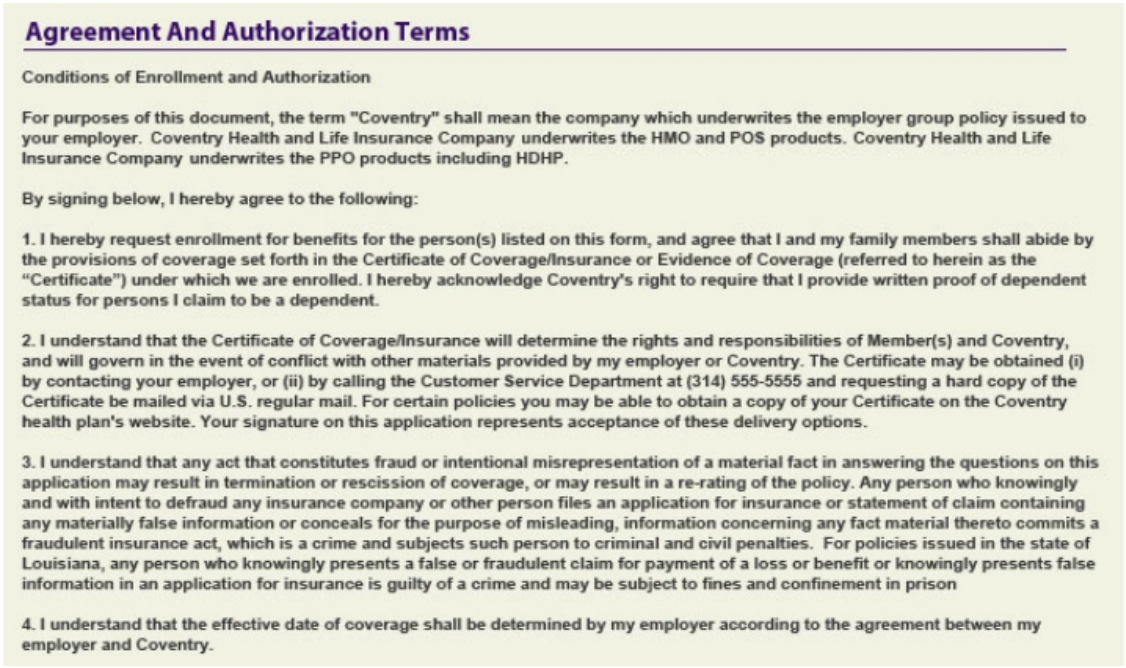


The “Enrollee Name” drop down list is populated with the Subscriber’s name and any enrolling dependent’s names.

Once all the required information is provided, the user will click Submit and continue through the verification process.



The verification process provides the subscriber with the opportunity to review all the information asked during enrollment and the responses they provided. If any information needs to be corrected, the subscriber can make the changes and re-verify before providing their electronic signature.



Agreement And Authorization Terms

Conditions of Enrollment and Authorization

For purposes of this document, the term "Coventry" shall mean the company which underwrites the employer group policy issued to your employer. Coventry Health and Life Insurance Company underwrites the HMO and POS products. Coventry Health and Life Insurance Company underwrites the PPO products including HDHP.

By signing below, I hereby agree to the following:

1. I hereby request enrollment for benefits for the person(s) listed on this form, and agree that I and my family members shall abide by the provisions of coverage set forth in the Certificate of Coverage/Insurance or Evidence of Coverage (referred to herein as the "Certificate") under which we are enrolled. I hereby acknowledge Coventry's right to require that I provide written proof of dependent status for persons I claim to be a dependent.

2. I understand that the Certificate of Coverage/Insurance will determine the rights and responsibilities of Member(s) and Coventry, and will govern in the event of conflict with other materials provided by my employer or Coventry. The Certificate may be obtained (i) by contacting your employer, or (ii) by calling the Customer Service Department at (314) 555-5555 and requesting a hard copy of the Certificate be mailed via U.S. regular mail. For certain policies you may be able to obtain a copy of your Certificate on the Coventry health plan's website. Your signature on this application represents acceptance of these delivery options.

3. I understand that any act that constitutes fraud or intentional misrepresentation of a material fact in answering the questions on this application may result in termination or rescission of coverage, or may result in a re-rating of the policy. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. For policies issued in the state of Louisiana, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

4. I understand that the effective date of coverage shall be determined by my employer according to the agreement between my employer and Coventry.

5. I authorize any physician, hospital, other medical provider, and persons or organizations involved in utilization review, peer review and other health plan administrative duties to disclose to Coventry any medical information, including, but not limited to, individually identifiable health information relating to diagnosis, prognosis, treatment, and payment for any physical and/or mental illness including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) relating to any individuals applying for enrollment by this form. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Coventry. For underwriting purposes, this authorization is valid for thirty (30) months from the date this form is signed, except for policies issued in the States of Nebraska, South Dakota, West Virginia , Wyoming, and Kansas where such authorization shall remain valid for twenty-four (24) months.

6. On behalf of myself and my enrolled dependents, I authorize Coventry to use or disclose to third parties the information contained in this enrollment form for purposes of administering health insurance benefits including treatment, payment, or health care operations, as those terms are explained in detail in Coventry's Notice of Privacy Practices and to the extent permitted by law.

7. I understand that certain covered medical services must be authorized by Coventry. I understand and agree that I may be personally responsible for all costs and charges for any health care services or prescription drugs for which I do not follow Coventry's prior authorization requirements. If the plan I am enrolling in is an HMO plan, then I understand that I must obtain medical services from a participating provider unless otherwise authorized by Coventry.

8. I authorize deductions from my earnings of the required contribution, if any, toward the cost of Coventry coverage (if applicable).

9. I understand that it is my responsibility to report to my employer any changes in the eligibility of the individuals listed. Also, any change in medical condition and any treatment or advice from a physician or provider, for you or anyone on this application, that occurs in the period between the date the application is signed and the policy/coverage effective date must be immediately reported to Coventry. Omissions of updated information/treatment/advice may result in coverage being rescinded or denied.

10. I understand that my coverage and benefits are contingent upon prompt payment of premiums. If my employer fails to make timely payment of premiums, Coventry may terminate this policy retroactively to the last date for which premium was paid or, in certain states, on the last day of the premium grace period following appropriate notice.

11. I understand that this policy may not cover all health care expenses. I understand that I must read my Certificate carefully to determine which health care services are covered.

12. I understand I am enrolling in a health care plan which may require that health care services be provided by participating providers. I also understand that failure to use a participating provider may result in reduced coverage or no coverage for services I receive, and I will be fully responsible for any and all costs not covered by Coventry. I understand that my Certificate provides additional details explaining the use of participating and non-participating providers under the plan. I have received a list of the participating providers, or if not, I understand that a list of participating providers is available to be (i) on the health plan's website or (ii) upon request. I understand that a provider's participating status may change from time to time and it is my responsibility to verify the provider's participation status prior to receiving services. I understand that I may verify provider status in one of two ways. First, by checking Coventry's website. Second, I may call Customer Service at the number listed on my Member ID card.

13. I understand that Coventry does not directly employ any participating providers or facilities. I further understand that Coventry provides the following summary of financial arrangements with the health care providers who are participating in the Coventry network:
(a) Hospital providers are paid according to a contract that includes inpatient per diems, case rates and discounted fee for service arrangements depending on a specific service provided.
(b) Physicians are paid through capitation or discounted fee for service in accordance with a specific agreed upon fee schedule.
(c) Other ancillary services including laboratory services, home health, skilled nursing and hospice are paid either on a contracted fee schedule or, where permitted by law, a capitation arrangement.

14. I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, birth, adoption, placement for adoption or court order. However, for policies issued in North Carolina, there is no time limit for enrollment following an issuance of a court order. If you reside in Arkansas, you may enroll a newborn dependent within 90 days of the child's birth or before the next premium due date, which ever is later. My dependents may also be eligible for special enrollment during the 60 days following the loss of Medicaid/CHIP coverage.

15. **NOTICE ABOUT YOUR PRE-EXISTING CONDITION LIMITATIONS.** If this plan imposes a pre-existing condition exclusion for employees and dependents, then I understand and agree to the following: If you have medical condition that existed prior to enrolling in this Coventry plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis care or treatment was recommended or received within a six-month period prior to your enrollment date. The pre-existing condition exclusion does not apply to children under 19 years old , to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption or placement for adoption or foster care. Eligible children (newborns, adoptive children, foster children and those added as a result of a court order) are not subject to this exclusion period when enrolled more than 31 days after one of the events listed above if your coverage type or the premiums owed are not affected by adding the child. However, for policies issued in North Carolina, there is no time limit for enrollment following an issuance of a court order. When applicable, this exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.* However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days (90 days for policies issued in the States of Georgia and Wyoming). To reduce the 12 month exclusion period by your creditable coverage, you should provide Coventry with a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, Coventry will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact Coventry if you need help demonstrating creditable coverage. (* In South Carolina, the exclusion may last up to 12 months from your first date of coverage, from the start of your waiting period or from the date of your last receipt of medical care, treatment, or supplies for the condition, whichever occurs first.) If you are covered under a Florida policy that has fewer than two employees, the preexisting condition exclusion period described above may last up to 24 months following the employee's effective date of coverage.

16. I understand that disputes regarding coverage and benefits may be resolved in accordance with Coventry's Member Grievance and Appeals procedures set forth in the Certificate.

17. I hereby represent that all information and statements furnished by me are true and complete to the best of my knowledge. I understand that any fraud or intentional misrepresentation of material fact including pre-existing conditions may result in the termination or rescission (back to the effective date) of my or any dependent's coverage and that I will be financially responsible for any costs incurred following the date of termination or rescission. Any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony.

18. If you are enrolling in an HMO product in the Commonwealth of Virginia, by signing below you acknowledge that you have been offered an out-of-network plan.

19. For policies issued in the state of Louisiana, I understand that I can revoke my authorization set forth herein at any time and my revocation shall immediately terminate the authorization.

☐ Agreed to and accepted by:

BACK SUBMIT

Signature History

Name	User ID	Date	Time	IP Address

Once signed off, the verification can be printed and / or saved by the user as a copy of their application. The system populates and records the signature history for verification purposes.

NEW ENROLLMENT & CHANGE FORM
[2 - 99 Eligible Employees]

PPO products are underwritten by Coventry Health and Life Insurance Company, Inc.

COVENTRY
Health and Life Insurance Company

Incompete information may delay the processing of your enrollment and/or your member ID card.

EMPLOYER INFORMATION: To Be Completed By Employer

Company Name:	Group No. (10 digits):	Date Employed Full Time:	Effective Date of Coverage:	Benefits Administrator Approval:	Date:

Reason for Enrollment:
❑ New Group ❑ New Hire ❑ Open Enrollment
❑ Cobra ❑ Hardship ❑ Other:________________________

Qualifying event ________________________ Date ___/___/___

Reason for Change: ❑ Addition ❑ Address/Phone ❑ Coverage ❑ Other:________________________
❑ Name Change:________________________
❑ [PCP Change Reason:]________________________
❑ Term Dependent Reason & Date:________________________
❑ Term Subscriber Reason & Date:________________________

Type of Coverage:
❑ Employee ❑ Employee Spouse
❑ Employee/Children
❑ Employee/Spouse/Children ❑ Waive

Employee Status:
❑ Hourly ❑ Salary ❑ COBRA ❑ Retired
❑ Other________________________

EMPLOYEE INFORMATION: To Be Completed By Employee

If address and phone numbers of covered dependents are different from that of policy holder, please attach the information on a separate sheet of paper.

Last Name:	First Name:	MI:	Social Security Number:

Street Address:	Work Phone and Area Code:

City:	State:	Zip Code:	Home Phone and Area Code:

Marital Status:
❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

Product Slections (Please write in plan number):
❑ PPO: ________________
❑ Other: ________________________
❑ None/waive

MEMBER INFORMATION: Family Members to be Covered and Physician Selection

<u>All areas below must be filled out for each family member or it will delay processing enrollment.</u> If "other" is checked, please indicate the nature of that relationship and include any appropriate legal documents.

Relationship	Add/ Delete	Last Name	First Name	M.I.	Social Security Number	Sex	Date of Birth Month	Day	Year	Height/ Weight	
❑ Self	❑ Add ❑ Delete					❑ M ❑ F				H: W:	
❑ Husband ❑ Wife	❑ Add ❑ Delete					❑ M ❑ F				H: W:	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				H: W:	❑ Student ❑ Disabled
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				H: W:	❑ Student ❑ Disabled
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				H: W:	❑ Student ❑ Disabled
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				H: W:	❑ Student ❑ Disabled

DRAFT
For review only

OTHER HEALTH INSURANCE INFORMATION: Complete or Write N/A

Name of Policyholder:	Birthdate (mo/day/yr):	Social Security Number:

Name of Employer:	Name of Insurance Company of Health & Welfare Plan:

Effective Date:	Insurance Policy Number:	Group Number:

List of Family Members Covered:	Covered and on Medicare:	Beneficiary Number:	Medicare A Eff. Date:	Medicare B Eff. Date:

REQUIRED INFORMATION FOR MEDICALLY UNDERWRITTEN GROUPS

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, Intelliscript, health plan, insurance company, Medical Information Bureau, third party administrator, claims administrator, employer, governmental agency, or other person or firm to disclose my (or my dependents') personal health information and other non-medical information (including but not limited to copies of records concerning advice, diagnosis, prognosis, treatment, prescription and/or payment information relating to physical or mental illness, including without limitation, information relating to acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), AIDS related complex (ARC), or the use of drugs or alcohol) to Coventry Health Care and to Coventry Health and Life Insurance Company, Inc. (collectively referred to as "Coventry") and to Coventry's authorized representatives and affiliates.

I HAVE READ AND AGREE TO THE STATEMENT ABOVE

Employee Signature:	Employee Printed Name:	Date:
Spouse's Signature:	Spouse's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:

Incomplete forms will be returned to you. This could result in delayed ID card(s), denied claims or even lack of coverage. Please make sure your form is complete before you submit it.

AGREEMENT: Please read the following carefully.

Please read the following carefully. It is part of the agreement between you and Coventry Health and Life Insurance Company, Inc. (referred to as "Health Plan").

1. I apply for membership in or waiver of the Health Plan for myself and for any eligible dependents listed. If enrolled, I authorize my employer to make deductions, if any, toward the premium cost of the Health Plan.
2. When enrolled, I and my eligible dependents shall abide by the provisions of coverage in the Group Policy/Enrollment Agreement, Certificate/Evidence of Coverage, Schedules and any applicable Riders under which we are enrolled.
3. By signing this form, I authorize my employer, & any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to the Health Plan, or receive from the Health Plan, any medical or claim information pertaining to the persons identified in this enrollment form receiving or applying for coverage under this plan, as may be necessary to enable the Health Plan to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers, all of which shall be conducted in accordance with state and federal confidentiality laws. The Health Plan will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by the Health Plan.
5. I understand that my membership may be cancelled for the following reasons: (1) failure to pay premiums due for which I am legally responsible, (2) fraud or material misrepresentation in enrollment or in the use of services of facilities, or any reason(s) listed in my Certificate or Evidence of Coverage.
6. I understand that it is my responsibility to report to the Health Plan any change in the eligibility for myself or my dependents.
7. Any fraudulent or intentional misrepresentation of material fact provided on this application may render this application void and result in retroactive cancellation (i.e. rescission) of your policy to your enrollment date. You will receive thirty (30) days advance notice prior to rescission of the policy.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

By signing this form I certify ALL information given is true and accurate.

Applicant's Signature:_____ **Date:** _____

GENERAL PROVISIONS

1. ENROLLMENT RIGHTS NOTICE (Waived Coverage) - I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, birth, adoption, placement for adoption or court order.

2. RESOLUTION OF DISPUTES - Please refer to the Certificate of Coverage, which outlines in detail the Health Plan's Member Grievance and Appeals Procedure.

FOR HEALTH PLAN USE ONLY			
Group Number:	Subscriber No.:	Date Entered/By:	Effective Date:

NEW ENROLLMENT & CHANGE FORM
[99+ Eligible Employees]

PPO products are underwritten by Coventry Health and Life Insurance Company, Inc.

COVENTRY Health and Life Insurance Company

Incompleteinformation may delay the processing of your enrollment and/or your member ID card.

EMPLOYER INFORMATION: To Be Completed By Employer

Company Name:	Group No. (10 digits):	Date Employed Full Time:	Effective Date of Coverage:	Benefits Administrator Approval:	Date:

Reason for Enrollment:
❑ New Group ❑ New Hire ❑ Open Enrollment
❑ Cobra ❑ Hardship ❑ Other:________________

Qualifying event ____________________ Date ___/___/___

Reason for Change: ❑ Addition ❑ Address/Phone ❑ Coverage ❑ Other:________________
❑ Name Change:________________
❑ [PCP Change Reason:]________________
❑ Term Dependent Reason & Date:________________
❑ Term Subscriber Reason & Date:________________

Type of Coverage:
❑ Employee ❑ Employee Spouse
❑ Employee/Children
❑ Employee/Spouse/Children ❑ Waive

Employee Status:
❑ Hourly ❑ Salary ❑ COBRA ❑ Retired
❑ Other________________

EMPLOYEE INFORMATION: To Be Completed By Employee

If address and phone numbers of covered dependents are different from that of policy holder, please attach the information on a separate sheet of paper.

Last Name:	First Name:	MI:	Social Security Number:

Street Address:	Work Phone and Area Code:

City:	State:	Zip Code:	Home Phone and Area Code:

Marital Status:
❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

Product Slections (Please write in plan number):
❑ PPO: ________________
❑ Other: ________________
❑ None/waive

MEMBER INFORMATION: Family Members to be Covered and Physician Selection

All areas below must be filled out for each family member or it will delay processing enrollment. If "other" is checked, please indicate the nature of that relationship and include any appropriate legal documents.

Relationship	Add/ Delete	Last Name	First Name	M.I.	Social Security Number	Sex	Date of Birth Month	Day	Year	Height/ Weight	
❑ Self	❑ Add ❑ Delete					❑ M ❑ F				H: W:	
❑ Husband ❑ Wife	❑ Add ❑ Delete					❑ M ❑ F				H: W:	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				H: W:	❑ Student ❑ Disabled
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				H: W:	❑ Student ❑ Disabled
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				H: W:	❑ Student ❑ Disabled
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				H: W:	❑ Student ❑ Disabled

DRAFT
For review only

OTHER HEALTH INSURANCE INFORMATION: Complete or Write N/A

Name of Policyholder:	Birthdate (mo/day/yr):	Social Security Number:

Name of Employer:	Name of Insurance Company of Health & Welfare Plan:

Effective Date:	Insurance Policy Number:	Group Number:

List of Family Members Covered:	Covered and on Medicare:	Beneficiary Number:	Medicare A Eff. Date:	Medicare B Eff. Date:

REQUIRED INFORMATION FOR MEDICALLY UNDERWRITTEN GROUPS

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, Intelliscript, health plan, insurance company, Medical Information Bureau, third party administrator, claims administrator, employer, governmental agency, or other person or firm to disclose my (or my dependents') personal health information and other non-medical information (including but not limited to copies of records concerning advice, diagnosis, prognosis, treatment, prescription and/or payment information relating to physical or mental illness, including without limitation, information relating to acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), AIDS related complex (ARC), or the use of drugs or alcohol) to Coventry Health Care and to Coventry Health and Life Insurance Company, Inc. (collectively referred to as "Coventry") and to Coventry's authorized representatives and affiliates.

I HAVE READ AND AGREE TO THE STATEMENT ABOVE

Employee Signature:	Employee Printed Name:	Date:
Spouse's Signature:	Spouse's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:

Incomplete forms will be returned to you. This could result in delayed ID card(s), denied claims or even lack of coverage. Please make sure your form is complete before you submit it.

AGREEMENT: Please read the following carefully.

Please read the following carefully. It is part of the agreement between you and Coventry Health and Life Insurance Company, Inc. (referred to as "Health Plan").

1. I apply for membership in or waiver of the Health Plan for myself and for any eligible dependents listed. If enrolled, I authorize my employer to make deductions, if any, toward the premium cost of the Health Plan.
2. When enrolled, I and my eligible dependents shall abide by the provisions of coverage in the Group Policy/Enrollment Agreement, Certificate/Evidence of Coverage, Schedules and any applicable Riders under which we are enrolled.
3. By signing this form, I authorize my employer, & any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to the Health Plan, or receive from the Health Plan, any medical or claim information pertaining to the persons identified in this enrollment form receiving or applying for coverage under this plan, as may be necessary to enable the Health Plan to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers, all of which shall be conducted in accordance with state and federal confidentiality laws. The Health Plan will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by the Health Plan.
5. I understand that my membership may be cancelled for the following reasons: (1) failure to pay premiums due for which I am legally responsible, (2) fraud or material misrepresentation in enrollment or in the use of services of facilities, or any reason(s) listed in my Certificate or Evidence of Coverage.
6. I understand that it is my responsibility to report to the Health Plan any change in the eligibility for myself or my dependents.
7. Any fraudulent or intentional misrepresentation of material fact provided on this application may render this application void and result in retroactive cancellation (i.e. rescission) of your policy to your enrollment date. You will receive thirty (30) days advance notice prior to rescission of the policy.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

By signing this form I certify ALL information given is true and accurate.

Applicant's Signature:_____ **Date:** _____

GENERAL PROVISIONS

1. ENROLLMENT RIGHTS NOTICE (Waived Coverage) - I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, birth, adoption, placement for adoption or court order.

2. RESOLUTION OF DISPUTES - Please refer to the Certificate of Coverage, which outlines in detail the Health Plan's Member Grievance and Appeals Procedure.

FOR HEALTH PLAN USE ONLY			
Group Number:	Subscriber No.:	Date Entered/By:	Effective Date:

COVENTRY Health Care
Coventry Health and Life Insurance Company

Employee Enrollment/Waiver of Coverage
Statement of Health Form
[2-99] Eligible Employer Group

For items with ** please select a Reason for Enrollment OR a Reason for Change

A EMPLOYER INFORMATION: TO BE COMPLETED BY EMPLOYER

☐ **New Group** ☐ **New Enrollment** ☐ **Change** ☐ **Waive**

Company Name:

Group No.:

Date Employed Full Time: / / /

Effective Date: / / /

**Reason for Enrollment:

☐ New Group ☐ New Hire
☐ COBRA ☐ Retired
☐ Open Enrollment ☐ Qualifying Event (Reason) _____

** Reason for Change:
(Please check all that apply and include supporting documentation.)

☐ Enroll Dependent ☐ Terminate Dependent
☐ Terminate Subscriber ☐ Name Change (Previous Name)
☐ Address/Phone

Pre-existing conditions exclusion period is 12 months for timely enrollees and 18 months for late enrollees unless you provide proof of coverage from your prior plan(s).

Termination Reason:
☐ Group Request ☐ Member Request ☐ Deceased

EMPLOYEE STATUS:
☐ Active ☐ COBRA / State Continuation ☐ Other _____

☐ Salary ☐ Hourly ☐ Number of hours per week: ___

Benefits Administrator Approval:

Date:

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

☐ **PPO** ☐ **None / Waive** (Please complete section E) ☐ **Other** _____

Last Name

First Name

MI

Gender
☐ Male ☐ Female

Birth date / /

Social Security Number - -

Address

City

State

Zip

Email Address

Height
Feet :

Inches:

Weight:

Marital Status:
☐ Single ☐ Divorced
☐ Married ☐ Separated

Tobacco Use:
☐ Yes
☐ No

Work Phone - -

Home Phone - -

C FAMILY MEMBERS TO BE COVERED OR DELETED

☐ Add
☐ Delete

Last Name

First Name

MI

Gender
☐ Male
☐ Female

Student/Disabled
☐ Student
☐ Disabled

Birth date / /

Social Security Number - -

Out of Area Dependent
☐ Yes ☐ No

Tobacco Use
☐ Yes ☐ No

Relationship
☐ Spouse ☐ Child

Height
Feet :

Inches:

Weight (lbs):

Zip Code:

Enrollee Name: _____

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: / /
Social Security Number: - -
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet :
Inches:
Weight (lbs):
Zip Code:

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: / /
Social Security Number: - -
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet :
Inches:
Weight (lbs):
Zip Code:

D OTHER MEDICAL INFORMATION AND/OR PHARMACY COVERAGE INFORMATION

[When coverage with Coventry begins, will you or any of your family members have any other medical insurance coverage? ☐ Yes ☐ No

Within the past 63 days, have you or any of your covered Dependents had any other individual or other group medical coverage, including Medicare/Medicaid? ☐ Yes ☐ No

If you answered yes to either, please complete the following:]

COVERAGE TYPE:

☐ Group Policy ☐ Individual Policy ☐ Medicare ☐ Pharmacy ☐ Medicaid ☐ Tricare ☐ Other _____

Other medical coverage in effect at the same time as Coventry coverage (individual or other group coverage)? ☐ Yes ☐ No

Other Medical Insurance Carrier Name	Policy Number	Effective Date	Termination Date
		/ /	/ /

Other Coverage Type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family

Prior medical coverage during the past 18 months (individual or other group coverage)? ☐ Yes ☐ No

Prior Medical Insurance Carrier Name	Policy Number	Effective Date	Termination Date
		/ /	/ /

Prior Coverage Type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family

Medicare Information

☐ **Subscriber** or ☐ **Dependent**

Part A / /
Part B / /
Part D / /

Effective Date: / /

Reason for Medicare Eligibility

☐ Over 65 ☐ Kidney Disease (ESRD) ☐ Disabled
☐ ALS (Lou Gehrig's Disease)

Medicare #

☐ **Subscriber** or ☐ **Dependent**

Part A / /
Part B / /
Part D / /

Effective Date: / /

Reason for Medicare Eligibility

☐ Over 65 ☐ Kidney Disease (ESRD) ☐ Disabled
☐ ALS (Lou Gehrig's Disease)

Medicare #

Enrollee Name: _____

E WAIVER (If applicable)

I have declined to apply for coverage for ☐ Myself ☐ Spouse ☐ Dependents.

Reason for waiving:

☐ Other health coverage ☐ Spousal coverage ☐ Other reason (please explain):_____

If you are waiving/declining medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, adoption or placement for adoption, and within 90 days after a birth. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period and a pre-existing condition exclusion period may apply.

_____ _____

Employee Signature (only if you are waiving coverage) Date:

F HEALTH INFORMATION (Used for rating purposes only. Incomplete answers could delay the decision on your request for coverage.)

Please provide the health history for the last 5 years for you and any other family members applying for coverage on this enrollment form. This includes but is not limited to, all of the listed conditions as well as any condition(s) which would have caused an ordinary prudent person to seek medical advice, diagnosis, care, or treatment as well as a condition for which medical advice, diagnosis, care or treatment was recommended or received.

Please check ☑ all applicable Yes/No responses. Circle all conditions that apply and give further details under "Additional Medical Details."

1. Cancer, tumor, or cyst?	☐ Yes	☐ No	14. HIV or AIDS?	☐ Yes	☐ No
2. Epilepsy, stroke, or paralysis?	☐ Yes	☐ No	15. Thyroid, pituitary, pancreatic, glandular, or disorder requiring growth hormones?	☐ Yes	☐ No
3. Head or spinal injuries, Muscular Dystrophy, Cerebral Palsy or Multiple Sclerosis?	☐ Yes	☐ No	16. Sleep apnea or diseases of the throat, ears, nose, sinuses or eyes (except corrective lenses)?	☐ Yes	☐ No
4. Neck or back pain, disorders of the spine, or disk herniation/bulge?	☐ Yes	☐ No	17. Arthritis, joint replacement, Lupus, fibromyalgia, connective tissue disease, fractures, limb loss, vasculitis, or peripheral vascular disease?	☐ Yes	☐ No
5. Any blood disorder (such as: hemophilia, anemia, sickle cell anemia, etc.)?	☐ Yes	☐ No	18. Hepatitis, Type: A, B, C, D, or autoimmune hepatitis (Please circle which type). Any other liver disorder or disease?	☐ Yes	☐ No
6. Bladder or kidney disorders such as: kidney stones, Polycystic Kidney Disease, kidney failure, renal insufficiency or on dialysis.	☐ Yes	☐ No	19. Alcohol or substance abuse, mental or nervous disorder?	☐ Yes	☐ No
7. Prostate, testicular, uterine or breast conditions?	☐ Yes	☐ No	20. Any stem cell or organ transplant planned, recommended, or already performed?	☐ Yes	☐ No
8. Ulcerative Colitis, Crohn's, diverticulitis, stomach ulcers, acid reflux, hernia, gallbladder, or rectal disorders?	☐ Yes	☐ No	21. Is anyone listed in this enrollment form currently pregnant, an expectant or surrogate parent, or in the process of adopting a child? (If yes, please include expected delivery date under "Additional Medical Details.")	☐ Yes	☐ No
9. Emphysema, COPD, Cystic Fibrosis, Sarcoidosis, or any other lung/respiratory disorder or disease?	☐ Yes	☐ No	22. Any hospitalizations in the last 5 years? (Please give full details under "Additional Medical Details.")	☐ Yes	☐ No
10. Asthma, allergies, or hay fever?	☐ Yes	☐ No	23. Any future surgeries discussed, planned, or recommended? (Please give full details under "Additional Medical Details.")	☐ Yes	☐ No
11. Diabetes? Type I or Type II? (Please give full details under "Additional Medical Details.")	☐ Yes	☐ No	24. Currently taking any prescription medications? (Please give full details under "Additional Medical Details," and include the condition for which the medication is needed.)	☐ Yes	☐ No
12. Hypertension (high blood pressure)?	☐ Yes	☐ No	25. Are there any other medical conditions not listed above? (Please give full details under "Additional Medical Details.")	☐ Yes	☐ No
13. Heart disease (including but not limited to irregular heartbeat, heart murmur, regurgitation, chest pain, heart attack, congestive heart failure, heart valve conditions, angioplasty, stent, bypass, or aortic aneurysm)?	☐ Yes	☐ No			

Enrollee Name: ___________________________________

ADDITIONAL MEDICAL DETAILS (continued from Section F)

I understand that for questions 1-25 that if I have failed to provide complete and accurate health information that this could result in re-rating of my entire employer group's health insurance premium or rescission (termination) of my coverage. ***Please initial:*** ___ ☐ **Yes** ☐ **No**

Please give full details for all YES answers above. If necessary, attach a signed and dated sheet with additional medical information.

Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:

Enrollee Name: _____

G AUTHORIZATION AND AGREEMENT

I hereby make the following authorizations for myself and for any of my dependents who are under the age of eighteen (18) and who are applying for coverage hereunder:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, Medical Information Bureau, third party administrator, claims administrator, employer, governmental agency, or other person or firm to disclose my (or my dependents') personal health information and other non-medical information (including but not limited to copies of records concerning advice, diagnosis, prognosis, treatment, prescription and/or payment information relating to physical or mental illness, including without limitation, information relating to acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), AIDS related complex (ARC), or the use of drugs or alcohol) to Coventry Health and Life Insurance Company, Inc. and to Coventry's authorized representatives and affiliates.

I authorize Coventry to research and review its own records for information related to my health. I understand information obtained with my authorization may be re-disclosed by Coventry as permitted or required by law and in some instances may no longer qualify for protection under Federal and state privacy laws. I understand that my authorization is voluntary and that such information will be used by Coventry for the purpose of evaluating my employer group's application for health insurance. I understand that no action will be taken on my health information without my signed authorization.

I authorize Coventry to use or disclose the information I provide (or that Coventry has or received from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of Coventry prior to the date revocation is received by Coventry.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

I UNDERSTAND AND AGREE THAT I MUST PERSONALLY BEAR ALL COSTS IF I USE HEALTH CARE SERVICES OR PURCHASE DRUGS AND DO NOT FOLLOW COVENTRY'S PRIOR AUTHORIZATION REQUIREMENTS.

I understand that I or my authorized representative may receive a copy of this Authorization and Agreement upon request.

H I HAVE READ AND AGREE TO THE STATEMENTS ABOVE.

Employee Signature:	Employee Printed Name:	Date:
Spouse's Signature:	Spouse's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:

INCOMPLETE FORMS WILL BE RETURNED TO YOU. THIS COULD RESULT IN DELAYED ID CARD(S), DENIED CLAIMS, OR EVEN LACK OF COVERAGE. PLEASE MAKE SURE YOUR FORM IS COMPLETE BEFORE YOU SUBMIT IT.

TREATMENT OF GENETIC INFORMATION

A. Non-Discrimination Policy

Coventry will not take any of the actions listed below based on: (1) its knowledge of any Genetic Information concerning an Employee or an Employee's family member; (2) its knowledge of an Employee's or Employee's family member's request for, or receipt of, genetic services; (3) its knowledge of an Employee's or an Employee's family member's refusal to submit to a Genetic Test or to make available the results of a Genetic Test.

- Terminate, restrict, limit, or otherwise apply conditions to the coverage of the Employee or family dependent of the Employee under the Policy.
- Cancel, or refuse to renew, the coverage of the Employee or family dependent.
- Deny coverage or exclude the Employee or family dependent from coverage.
- Impose a rider that excludes coverage for certain benefits or services.
- Establish different premium rates or cost sharing for coverage.
- Otherwise discriminate against an individual or family member in the provision of insurance.

The term "Genetic Information" as used above means all information about a person's genes, gene products, inherited characteristics, family history, or family pedigree. The term "Genetic Test" as used above means any test for determining the presence or absence of Generic Characteristics in a person. A "Genetic Characteristic" is any gene or chromosome alteration of a gene or chromosome, that is scientifically or medically believed to cause a disease, disorder, or syndrome to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome.

B. Consent to Obtain Genetic Information

Coventry must receive an Employee's or family dependent's written and informed consent, or a written and informed consent of his or her representative, before obtaining Genetic Information from an Employee or a family dependent or from a sample of his or her DNA.

Coventry will provide a copy of the written consent to the Employee. The written consent may be revoked or amended, in whole or in part, at any time. Coventry will not treat a general authorization for a release of medical records or medical information as a written consent for the disclosure of Genetic Information. The authorization shall be invalid if it is used for any purpose other than the described purpose for which disclosure is made.

C. Ownership of Genetic Information

An Employee's or family dependent's Genetic Information is the property of the Employee or family dependent and is not the property of Coventry or its representatives.

Enrollee Name: ______________________________

ADDITIONAL DEPENDENTS FORM (continued from Section C)

☐ Add ☐ Delete
Last Name
First Name
MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight:
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

☐ Add ☐ Delete
Last Name
First Name
MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight:
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

☐ Add ☐ Delete
Last Name
First Name
MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight:
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

☐ Add ☐ Delete
Last Name
First Name
MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight:
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

☐ Add ☐ Delete
Last Name
First Name
MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight (lbs):
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

COVENTRY Health Care
Coventry Health and Life Insurance Company

Employee Enrollment/Waiver of Coverage
Statement of Health Form
[2-99] Eligible Employer Group

For items with ** please select a Reason for Enrollment OR a Reason for Change

A EMPLOYER INFORMATION: TO BE COMPLETED BY EMPLOYER

☐ **New Group** ☐ **New Enrollment** ☐ **Change** ☐ **Waive**

Company Name:

Group No.:

Date Employed Full Time: / / /

Effective Date: / / /

**Reason for Enrollment:

- ☐ New Group
- ☐ New Hire
- ☐ COBRA
- ☐ Retired
- ☐ Open Enrollment
- ☐ Qualifying Event (Reason) _____

** Reason for Change:
(Please check all that apply and include supporting documentation.)

- ☐ Enroll Dependent
- ☐ Terminate Dependent
- ☐ Terminate Subscriber
- ☐ Name Change (Previous Name)
- ☐ Address/Phone

Pre-existing conditions exclusion period is 12 months for timely enrollees and 18 months for late enrollees unless you provide proof of coverage from your prior plan(s).

Termination Reason:
☐ Group Request ☐ Member Request ☐ Deceased

EMPLOYEE STATUS:
☐ Active ☐ COBRA / State Continuation ☐ Other _____

☐ Salary ☐ Hourly ☐ Number of hours per week: ___

Benefits Administrator Approval:

Date:

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:
☐ **PPO** ☐ **None / Waive** (Please complete section E) ☐ **Other** _____

Last Name

First Name

MI

Gender
☐ Male ☐ Female

Birth date / /

Social Security Number - -

Address

City

State

Zip

Email Address

Height
Feet :

Inches:

Weight:

Marital Status:
☐ Single ☐ Divorced
☐ Married ☐ Separated

Tobacco Use:
☐ Yes ☐ No

Work Phone - -

Home Phone - -

C FAMILY MEMBERS TO BE COVERED OR DELETED

☐ Add
☐ Delete

Last Name

First Name

MI

Gender
☐ Male
☐ Female

Student/Disabled
☐ Student
☐ Disabled

Birth date / /

Social Security Number - -

Out of Area Dependent
☐ Yes ☐ No

Tobacco Use
☐ Yes ☐ No

Relationship
☐ Spouse ☐ Child

Height
Feet :

Inches:

Weight (lbs):

Zip Code:

Enrollee Name: _____

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: / /
Social Security Number: - -
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet :
Inches:
Weight (lbs):
Zip Code:

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: / /
Social Security Number: - -
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet :
Inches:
Weight (lbs):
Zip Code:

D OTHER MEDICAL INFORMATION AND/OR PHARMACY COVERAGE INFORMATION

[When coverage with Coventry begins, will you or any of your family members have any other medical insurance coverage? ☐ Yes ☐ No

Within the past 63 days, have you or any of your covered Dependents had any other individual or other group medical coverage, including Medicare/Medicaid? ☐ Yes ☐ No

If you answered yes to either, please complete the following:]

COVERAGE TYPE:

☐ Group Policy ☐ Individual Policy ☐ Medicare ☐ Pharmacy ☐ Medicaid ☐ Tricare ☐ Other _____

Other medical coverage in effect at the same time as Coventry coverage (individual or other group coverage)? ☐ Yes ☐ No

Other Medical Insurance Carrier Name	Policy Number	Effective Date	Termination Date
		/ /	/ /

Other Coverage Type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family

Prior medical coverage during the past 18 months (individual or other group coverage)? ☐ Yes ☐ No

Prior Medical Insurance Carrier Name	Policy Number	Effective Date	Termination Date
		/ /	/ /

Prior Coverage Type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family

Medicare Information

☐ **Subscriber** or ☐ **Dependent**

Part A / /
Part B / /
Part D / /

Effective Date: / /

Reason for Medicare Eligibility

☐ Over 65 ☐ Kidney Disease (ESRD) ☐ Disabled
☐ ALS (Lou Gehrig's Disease)

Medicare #

☐ **Subscriber** or ☐ **Dependent**

Part A / /
Part B / /
Part D / /

Effective Date: / /

Reason for Medicare Eligibility

☐ Over 65 ☐ Kidney Disease (ESRD) ☐ Disabled
☐ ALS (Lou Gehrig's Disease)

Medicare #

Enrollee Name: ___________________________

E WAIVER (If applicable)

I have declined to apply for coverage for ☐ Myself ☐ Spouse ☐ Dependents.
Reason for waiving:

☐ Other health coverage ☐ Spousal coverage ☐ Other reason (please explain): ___________________________

If you are waiving/declining medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, adoption or placement for adoption, and within 90 days after a birth. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period and a pre-existing condition exclusion period may apply.

___________________________ ___________________________

Employee Signature (only if you are waiving coverage) Date:

F HEALTH INFORMATION

(Used for rating purposes only. Incomplete answers could delay the decision on your request for coverage.)

Please provide the health history for the last 5 years for you and any other family members applying for coverage on this enrollment form. This includes but is not limited to, all of the listed conditions as well as any condition(s) which would have caused an ordinary prudent person to seek medical advice, diagnosis, care, or treatment as well as a condition for which medical advice, diagnosis, care or treatment was recommended or received.

Please check ☑ all applicable Yes/No responses. Circle all conditions that apply and give further details in the appropriate section indicated below.

[1] AIDS, HIV, arthritis, bleeding, or clotting disorders, cancer, diabetes, disorder of the neck/back/spine, heart conditions, intestinal conditions, kidney (stones or failure), liver (cirrhosis, Hepatitis A, B, C, or D), lung conditions, organ transplant, stroke or vascular (blood vessel) disorders, tumor, alcohol or substance abuse, or mental or nervous disorders? ***Circle all that apply and give full details below.***	☐ Yes	☐ No
2) Any surgery or medical treatment discussed, planned, or recommended, that has not yet been done?	☐ Yes	☐ No
3) Currently pregnant, an expectant or surrogate parent, or in the process of adopting a child? (If yes, please include expected delivery date below.)	☐ Yes	☐ No
4) Any medical conditions which have not been disclosed above? ***(Please give full details below.)***	☐ Yes	☐ No
5) Currently taking any medication? ***(Please give full details and provide the condition for which the medication is needed below.)***	☐ Yes	☐ No
I understand that for questions above that if I have failed to provide complete and accurate health information that this could result in re-rating of my entire employer group's health insurance premium or rescission (termination) of my coverage. ***Please initial:*** ___	☐ **Yes**	☐ **No**

Please give full details for all YES answers above. If necessary, attach a signed and dated sheet with additional medical information.

Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:

Enrollee Name: _____

G AUTHORIZATION AND AGREEMENT

I hereby make the following authorizations for myself and for any of my dependents who are under the age of eighteen (18) and who are applying for coverage hereunder:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, Medical Information Bureau, third party administrator, claims administrator, employer, governmental agency, or other person or firm to disclose my (or my dependents') personal health information and other non-medical information (including but not limited to copies of records concerning advice, diagnosis, prognosis, treatment, prescription and/or payment information relating to physical or mental illness, including without limitation, information relating to acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), AIDS related complex (ARC), or the use of drugs or alcohol) to Coventry Health and Life Insurance Company, Inc. and to Coventry's authorized representatives and affiliates.

I authorize Coventry to research and review its own records for information related to my health. I understand information obtained with my authorization may be re-disclosed by Coventry as permitted or required by law and in some instances may no longer qualify for protection under Federal and state privacy laws. I understand that my authorization is voluntary and that such information will be used by Coventry for the purpose of evaluating my employer group's application for health insurance. I understand that no action will be taken on my health information without my signed authorization.

I authorize Coventry to use or disclose the information I provide (or that Coventry has or received from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of Coventry prior to the date revocation is received by Coventry.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

I UNDERSTAND AND AGREE THAT I MUST PERSONALLY BEAR ALL COSTS IF I USE HEALTH CARE SERVICES OR PURCHASE DRUGS AND DO NOT FOLLOW COVENTRY'S PRIOR AUTHORIZATION REQUIREMENTS.

I understand that I or my authorized representative may receive a copy of this Authorization and Agreement upon request.

H I HAVE READ AND AGREE TO THE STATEMENTS ABOVE.

Employee Signature:	Employee Printed Name:	Date:
Spouse's Signature:	Spouse's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:

INCOMPLETE FORMS WILL BE RETURNED TO YOU. THIS COULD RESULT IN DELAYED ID CARD(S), DENIED CLAIMS, OR EVEN LACK OF COVERAGE. PLEASE MAKE SURE YOUR FORM IS COMPLETE BEFORE YOU SUBMIT IT.

TREATMENT OF GENETIC INFORMATION

A. Non-Discrimination Policy
Coventry will not take any of the actions listed below based on: (1) its knowledge of any Genetic Information concerning an Employee or an Employee's family member; (2) its knowledge of an Employee's or Employee's family member's request for, or receipt of, genetic services; (3) its knowledge of an Employee's or an Employee's family member's refusal to submit to a Genetic Test or to make available the results of a Genetic Test.

- Terminate, restrict, limit, or otherwise apply conditions to the coverage of the Employee or family dependent of the Employee under the Policy.
- Cancel, or refuse to renew, the coverage of the Employee or family dependent.
- Deny coverage or exclude the Employee or family dependent from coverage.
- Impose a rider that excludes coverage for certain benefits or services.
- Establish different premium rates or cost sharing for coverage.
- Otherwise discriminate against an individual or family member in the provision of insurance.

The term "Genetic Information" as used above means all information about a person's genes, gene products, inherited characteristics, family history, or family pedigree. The term "Genetic Test" as used above means any test for determining the presence or absence of Generic Characteristics in a person. A "Genetic Characteristic" is any gene or chromosome alteration of a gene or chromosome, that is scientifically or medically believed to cause a disease, disorder, or syndrome to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome.

B. Consent to Obtain Genetic Information
Coventry must receive an Employee's or family dependent's written and informed consent, or a written and informed consent of his or her representative, before obtaining Genetic Information from an Employee or a family dependent or from a sample of his or her DNA.

Coventry will provide a copy of the written consent to the Employee. The written consent may be revoked or amended, in whole or in part, at any time. Coventry will not treat a general authorization for a release of medical records or medical information as a written consent for the disclosure of Genetic Information. The authorization shall be invalid if it is used for any purpose other than the described purpose for which disclosure is made.

C. Ownership of Genetic Information
An Employee's or family dependent's Genetic Information is the property of the Employee or family dependent and is not the property of Coventry or its representatives.

Enrollee Name: ________________________________

ADDITIONAL DEPENDENTS FORM (continued from Section C)

☐ Add ☐ Delete
Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight (lbs):
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

☐ Add ☐ Delete
Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight (lbs):
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

☐ Add ☐ Delete
Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight (lbs):
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

☐ Add ☐ Delete
Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight (lbs):
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

☐ Add ☐ Delete
Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Height Feet : Inches:
Weight (lbs):
Zip Code:
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No

Enrollee Name: ____________________________________

ADDITIONAL MEDICAL DETAILS (continued from Section F)

Question #	Person's Name	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:

COVENTRY Health Care
Coventry Health and Life Insurance Company

Employee Enrollment/Waiver of Coverage
Statement of Health Form
[99+ Eligible Employees]

For items with ** please select a Reason for Enrollment OR a Reason for Change

A EMPLOYER INFORMATION: TO BE COMPLETED BY EMPLOYER

☐ **New Group** ☐ **New Enrollment** ☐ **Change** ☐ **Waive**

Company Name:

Group No.:

Date Employed Full Time: ___ / ___ / ____

Effective Date: ___ / ___ / ____

**Reason for Enrollment:

☐ New Group ☐ New Hire
☐ COBRA ☐ Retired
☐ Open Enrollment ☐ Qualifying Event (Reason) _____

** Reason for Change:
(Please check all that apply and include supporting documentation.)

☐ Enroll Dependent ☐ Terminate Dependent
☐ Terminate Subscriber ☐ Name Change (Previous Name)
☐ Address/Phone

Pre-existing conditions exclusion period is 12 months for timely enrollees and 18 months for late enrollees unless you provide proof of coverage from your prior plan(s).

Termination Reason:
☐ Group Request ☐ Member Request ☐ Deceased

EMPLOYEE STATUS:
☐ Active ☐ COBRA / State Continuation ☐ Other _____

☐ Salary ☐ Hourly ☐ Number of hours per week: ___

Benefits Administrator Approval:

Date:

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

☐ **PPO** ☐ **None / Waive** (Please complete section E) ☐ **Other** _____

Last Name

First Name

MI

Gender
☐ Male ☐ Female

Birth date ___ / ___ / ____

Social Security Number ___ - ___ - ____

Address

City

State

Zip

Email Address

Height
Feet :

Inches:

Weight:

Marital Status:
☐ Single ☐ Divorced
☐ Married ☐ Separated

Tobacco Use:
☐ Yes
☐ No

Work Phone ___ - ___ - ____

Home Phone ___ - ___ - ____

C FAMILY MEMBERS TO BE COVERED OR DELETED

☐ Add
☐ Delete

Last Name

First Name

MI

Gender
☐ Male
☐ Female

Student/Disabled
☐ Student
☐ Disabled

Birth date ___ / ___ / ____

Social Security Number ___ - ___ - ____

Out of Area Dependent
☐ Yes ☐ No

Tobacco Use
☐ Yes ☐ No

Relationship
☐ Spouse ☐ Child

Height
Feet :

Inches:

Weight (lbs):

Zip Code:

Enrollee Name: _____

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: / /
Social Security Number: - -
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet :
Inches:
Weight (lbs):
Zip Code:

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: / /
Social Security Number: - -
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet :
Inches:
Weight (lbs):
Zip Code:

D OTHER MEDICAL INFORMATION AND/OR PHARMACY COVERAGE INFORMATION

[When coverage with Coventry begins, will you or any of your family members have any other medical insurance coverage? ☐ Yes ☐ No

Within the past 63 days, have you or any of your covered Dependents had any other individual or other group medical coverage, including Medicare/Medicaid? ☐ Yes ☐ No

If you answered yes to either, please complete the following:]

COVERAGE TYPE:

☐ Group Policy ☐ Individual Policy ☐ Medicare ☐ Pharmacy ☐ Medicaid ☐ Tricare ☐ Other _____

Other medical coverage in effect at the same time as Coventry coverage (individual or other group coverage)? ☐ Yes ☐ No

Other Medical Insurance Carrier Name	Policy Number	Effective Date	Termination Date
		/ /	/ /

Other Coverage Type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family

Prior medical coverage during the past 18 months (individual or other group coverage)? ☐ Yes ☐ No

Prior Medical Insurance Carrier Name	Policy Number	Effective Date	Termination Date
		/ /	/ /

Prior Coverage Type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family

Medicare Information

☐ **Subscriber** or ☐ **Dependent**

Part A / /
Part B / /
Part D / /

Effective Date: / /

Reason for Medicare Eligibility

☐ Over 65 ☐ Kidney Disease (ESRD) ☐ Disabled
☐ ALS (Lou Gehrig's Disease)

Medicare #

☐ **Subscriber** or ☐ **Dependent**

Part A / /
Part B / /
Part D / /

Effective Date: / /

Reason for Medicare Eligibility

☐ Over 65 ☐ Kidney Disease (ESRD) ☐ Disabled
☐ ALS (Lou Gehrig's Disease)

Medicare #

Enrollee Name: ___________________________________

E WAIVER (If applicable)

I have declined to apply for coverage for ☐ Myself ☐ Spouse ☐ Dependents.
Reason for waiving:

☐ Other health coverage ☐ Spousal coverage ☐ Other reason (please explain): ___________________________________

If you are waiving/declining medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, adoption or placement for adoption, and within 90 days after a birth. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period and a pre-existing condition exclusion period may apply.

_______________________________________ _______________________________

Employee Signature (only if you are waiving coverage) Date:

F HEALTH INFORMATION

(Used for rating purposes only. Incomplete answers could delay the decision on your request for coverage.)

Please provide the health history for the last 5 years for you and any other family members applying for coverage on this enrollment form. This includes but is not limited to, all of the listed conditions as well as any condition(s) which would have caused an ordinary prudent person to seek medical advice, diagnosis, care, or treatment as well as a condition for which medical advice, diagnosis, care or treatment was recommended or received.

Please check ☑ all applicable Yes/No responses. Circle all conditions that apply and give further details in the appropriate section indicated below.

[1] AIDS, HIV, arthritis, bleeding, or clotting disorders, cancer, diabetes, disorder of the neck/back/spine, heart conditions, intestinal conditions, kidney (stones or failure), liver (cirrhosis, Hepatitis A, B, C, or D), lung conditions, organ transplant, stroke or vascular (blood vessel) disorders, tumor, alcohol or substance abuse, or mental or nervous disorders? ***Circle all that apply and give full details below.***	☐ Yes	☐ No
2) Any surgery or medical treatment discussed, planned, or recommended, that has not yet been done?	☐ Yes	☐ No
3) Currently pregnant, an expectant or surrogate parent, or in the process of adopting a child? (If yes, please include expected delivery date below.)	☐ Yes	☐ No
4) Any medical conditions which have not been disclosed above? ***(Please give full details below.)***	☐ Yes	☐ No
5) Currently taking any medication? ***(Please give full details and provide the condition for which the medication is needed below.)***	☐ Yes	☐ No
I understand that for questions above that if I have failed to provide complete and accurate health information that this could result in re-rating of my entire employer group's health insurance premium or rescission (termination) of my coverage. ***Please initial:*** ___	☐ **Yes**	☐ **No**

Please give full details for all YES answers above. If necessary, attach a signed and dated sheet with additional medical information.

Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:

Enrollee Name: _____

G AUTHORIZATION AND AGREEMENT

I hereby make the following authorizations for myself and for any of my dependents who are under the age of eighteen (18) and who are applying for coverage hereunder:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, Medical Information Bureau, third party administrator, claims administrator, employer, governmental agency, or other person or firm to disclose my (or my dependents') personal health information and other non-medical information (including but not limited to copies of records concerning advice, diagnosis, prognosis, treatment, prescription and/or payment information relating to physical or mental illness, including without limitation, information relating to acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), AIDS related complex (ARC), or the use of drugs or alcohol) to Coventry Health and Life Insurance Company, Inc. and to Coventry's authorized representatives and affiliates.

I authorize Coventry to research and review its own records for information related to my health. I understand information obtained with my authorization may be re-disclosed by Coventry as permitted or required by law and in some instances may no longer qualify for protection under Federal and state privacy laws. I understand that my authorization is voluntary and that such information will be used by Coventry for the purpose of evaluating my employer group's application for health insurance. I understand that no action will be taken on my health information without my signed authorization.

I authorize Coventry to use or disclose the information I provide (or that Coventry has or received from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of Coventry prior to the date revocation is received by Coventry.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

I UNDERSTAND AND AGREE THAT I MUST PERSONALLY BEAR ALL COSTS IF I USE HEALTH CARE SERVICES OR PURCHASE DRUGS AND DO NOT FOLLOW COVENTRY'S PRIOR AUTHORIZATION REQUIREMENTS.

I understand that I or my authorized representative may receive a copy of this Authorization and Agreement upon request.

H I HAVE READ AND AGREE TO THE STATEMENTS ABOVE.

Employee Signature:	Employee Printed Name:	Date:
Spouse's Signature:	Spouse's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:

INCOMPLETE FORMS WILL BE RETURNED TO YOU. THIS COULD RESULT IN DELAYED ID CARD(S), DENIED CLAIMS, OR EVEN LACK OF COVERAGE. PLEASE MAKE SURE YOUR FORM IS COMPLETE BEFORE YOU SUBMIT IT.

TREATMENT OF GENETIC INFORMATION

A. Non-Discrimination Policy
Coventry will not take any of the actions listed below based on: (1) its knowledge of any Genetic Information concerning an Employee or an Employee's family member; (2) its knowledge of an Employee's or Employee's family member's request for, or receipt of, genetic services; (3) its knowledge of an Employee's or an Employee's family member's refusal to submit to a Genetic Test or to make available the results of a Genetic Test.

- Terminate, restrict, limit, or otherwise apply conditions to the coverage of the Employee or family dependent of the Employee under the Policy.
- Cancel, or refuse to renew, the coverage of the Employee or family dependent.
- Deny coverage or exclude the Employee or family dependent from coverage.
- Impose a rider that excludes coverage for certain benefits or services.
- Establish different premium rates or cost sharing for coverage.
- Otherwise discriminate against an individual or family member in the provision of insurance.

The term "Genetic Information" as used above means all information about a person's genes, gene products, inherited characteristics, family history, or family pedigree. The term "Genetic Test" as used above means any test for determining the presence or absence of Generic Characteristics in a person. A "Genetic Characteristic" is any gene or chromosome alteration of a gene or chromosome, that is scientifically or medically believed to cause a disease, disorder, or syndrome to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome.

B. Consent to Obtain Genetic Information
Coventry must receive an Employee's or family dependent's written and informed consent, or a written and informed consent of his or her representative, before obtaining Genetic Information from an Employee or a family dependent or from a sample of his or her DNA.

Coventry will provide a copy of the written consent to the Employee. The written consent may be revoked or amended, in whole or in part, at any time. Coventry will not treat a general authorization for a release of medical records or medical information as a written consent for the disclosure of Genetic Information. The authorization shall be invalid if it is used for any purpose other than the described purpose for which disclosure is made.

C. Ownership of Genetic Information
An Employee's or family dependent's Genetic Information is the property of the Employee or family dependent and is not the property of Coventry or its representatives.

Enrollee Name: ______________________________

ADDITIONAL DEPENDENTS FORM (continued from Section C)

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet: Inches:
Weight (lbs):
Zip Code:

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet: Inches:
Weight (lbs):
Zip Code:

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet: Inches:
Weight (lbs):
Zip Code:

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet: Inches:
Weight (lbs):
Zip Code:

☐ Add
☐ Delete

Last Name | First Name | MI

Gender: ☐ Male ☐ Female
Student/Disabled: ☐ Student ☐ Disabled
Birth date: __ __ / __ __ / __ __ __ __
Social Security Number: __ __ __ - __ __ - __ __ __ __
Out of Area Dependent: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Height Feet: Inches:
Weight (lbs):
Zip Code:

Enrollee Name: ___________________________________

ADDITIONAL MEDICAL DETAILS (continued from Section F)

Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:
Question #	**Person's Name**	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? ☐ Yes ☐ No If Yes, Please Explain:

AUTISM SPECTRUM DISORDER TREATMENT
PPO PLAN

This Autism Spectrum Disorder treatment Rider ("**Rider**") is underwritten and administered by Coventry Health and Life Insurance Company (**"CHL"**), and made a part of the Certificate of Coverage to which it is attached. Accordingly, all definitions, provisions, terms, limitations, exclusions and conditions of the Certificate of Coverage are applicable to this Rider.

SECTION I. DEFINITIONS

All definitions of the Certificate of Coverage to which this rider is attached shall apply except to the extent such terms are explicitly superceded or modified by this Rider.

Autism Spectrum Disorder: Any of the pervasive developmental disorders as defined by the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders," including:

(a) Autistic disorder;
(b) Asperger's disorder; and
(c) Pervasive developmental disorder not otherwise specified.

Applied Behavior Analysis: The design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

SECTION II. COVERED BENEFITS

Coverage is provided for Medically Necessary services for the diagnosis and treatment of Autism Spectrum Disorders in Members. Services must be prescribed, provided or ordered by a licensed Physician or licensed psychologist and may include habilitative or rehabilitative care, applied behavioral analysis when provided by or supervised by a Board Certified Behavior Analyst; pharmacy care, psychiatric care, psychological care, therapeutic care, and equipment determined to provide evidence-based treatment.

Coverage of Applied Behavior Analysis is provided for Medically Necessary services for members under eighteen (18) years of age.

SECTION III. SCHEDULE OF COPAYMENTS/ALLOWANCE

Coverage is provided if the service is Medically Necessary, Authorized (on a prospective and timely basis) by the CHL Medical Director.

Services are subject to a [$0-2,000] Copayment, [0-50%] Coinsurance [and/or] [a $0-$10,000 Deductible].

SECTION IV. CONDITIONS, LIMITATIONS AND EXCLUSIONS

Coverage must be Pre-Authorized and is subject to review for Medical Necessity that may be based in part on evidence of continued improvement as a result of the treatment.

Coverage of Applied Behavior Analysis is subject to an annual limit of fifty thousand ($50,000) dollars.

SECTION V. GENERAL PROVISIONS

A. Services must be Authorized in advance by Us.

B. The effective date of this Rider shall be the same date as the Benefit Agreement.

C. The Rider, or Coverage under this Rider, shall terminate for the reasons set forth in the Certificate of Coverage.

D. Nothing in this Rider shall otherwise extend, vary, alter or waive any of the benefits, exclusions, limitations or conditions contained in the Benefit Agreement, other than as stated in this Rider.

[INSERT EMPLOYER GROUP NAME]

_____

(Signature of Officer)

_____

(Date)

AMENDMENT
TO [INSERT PLAN NAME]
[INSERT NAME OF CERTIFICATE OF COVERAGE]

1. This Amendment (the "Amendment"), effective as of [INSERT DATE], amends the [INSERT PLAN NAME AND CERTIFICATE OF COVERAGE] (the "COC") and Schedule of Benefits to comply with the federal Patient Protection and Affordable Coverage Act of 2010 and the federal Health Care and Education Reconciliation Act of 2010 and regulations promulgated thereunder.

2. [INSERT HEALTH PLAN NAME] is executing this Amendment pursuant to Section [13.8 / 14.10 / 12.9 / 12.17 / 12.8] of the COC.

3. The following new subsection is hereby added to Section 6 of the COC:

Preventive Services	Medically Necessary Services as defined under the Patient Protection and Affordable Coverage Act of 2010 ("PPACA"), including any regulations promulgated thereunder, including: • Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; • With respect to infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and • With respect to women, such additional preventive care and screenings not described in bullet point one as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.	[Prior Authorization may be required.] **Note:** Prescription drugs that meet the definition of Preventive Services are covered under your applicable prescription drug rider.

4. The "Preventive Services for Adults and Children" subsection of the Schedule of Benefits is hereby deleted in its entirety and replaced with the following new subsection:

BENEFITS	MEMBER PAYS In Network
PREVENTIVE SERVICES (as defined in the Certificate of Coverage)	Covered in Full Note: Prescription drugs that meet the definition of Preventive Services are covered under your applicable prescription drug rider.

5. The following new subsection is hereby added to Pharmacy Rider of the COC, if applicable:

If [INSERT HEALTH PLAN] determines that an item covered under this prescription drug rider is required to be covered as a "preventive health service" under Section 2713(a) of the Public Health Service Act and 45 C.F.R. 147.130(a), as may be amended from time to time (together, the "Preventive Services Law"), such item shall be covered with no cost sharing requirement, such as a deductible, copayment, or coinsurance requirement, but may be subject to certain utilization management and/or formulary management requirements in accordance with the Preventive Services Law.

6. Capitalized terms not otherwise defined in this Amendment shall have the meaning set forth in the COC.

7. To the extent any provision of this Amendment conflicts with any of the provisions of the COC, the provisions of this Amendment shall govern. Except for the amendments made hereby, the COC remains in full force and effect.

[INSERT HEALTH PLAN NAME]

_____

By:
Its:

SERFF Tracking #:	*CVLA-128476517*	***State Tracking #:***		***Company Tracking #:***	*062012 - 05*
State:	*Arkansas*		***Filing Company:***	*Coventry Health and Life Insurance Co.*	
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*				
Product Name:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider*				
Project Name/Number:	*AR CHL GROUP PPO--Merged-Online-Mod. Aps, WP Am., Autism Rider/06132012 - 02*				

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	07/20/2012
Comments:	Please find attached the Flesch Reading Ease Test Certification.		
Attachment(s):			
6.27.12 - AR FLESCH READING EASE CERT.--Rx-Add.-AR Aut..pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	07/20/2012
Comments:	These are new and revised applications being submitted under the Form Schedule Tab.		

		Item Status:	**Status Date:**
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/20/2012
Comments:	Attached is the PPACA Uniform Compliance Summary for the AR CHL GROUP PPO product which includes the PPACA-related Women's Preventive Amendment.		
Attachment(s):			
7.20.12 - AR CHL GROUP PPO - PPACA Compliance Summary.pdf			

COVENTRY HEALTH AND LIFE INSURANCE COMPANY
5350 Poplar Avenue, Suite 390
Memphis, TN 38119

FLESCH READING EASE TEST

This is to certify that the form(s) listed below are in compliance with readability requirements pursuant to Arkansas Code Ann. 23-80-206 and have a readability score of forty (40) or higher.

The Flesch Test was applied to the forms as part of the policy, except that any of the following language may have been redacted: name and address of insurer, name or title of policy, table of contents, captions, subcaptions, policy language which was drafted to conform to any applicable law or regulation, any medical terminology or defined terms in the policy.

FORM NUMBER(S)

TN AR MS_RX11_CHL – Prescription Drug Rider ("Rider")
TNARMS Non-ERISA ADD -05.2012 ("Application")
AR CHL GROUP PPO –Autism Rider -06.2012 ("Rider")

Chief Financial Officer

DATE: June 27, 2012

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☑ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Coventry Health and Life Insurance Company	81973	CVLA-128476517 CVLA-127013547 FLHI-126789389	TN AR MS Group PPO_COC_10_CHL (9/2010) and associated documents	☑ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16G Group Health - Major Medical	**Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19**	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We do not have grandfathered plans.			
	Page Number: COC, Section 1.87, page 26			
H16G Group Health - Major Medical	**Eliminate Annual Dollar Limits on Essential Benefits** – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We do not have grandfathered plans.			
	Page Number: See Schedule of Benefits			
H16G Group Health - Major Medical	**Eliminate Lifetime Dollar Limits on Essential Benefits**	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☑ **Yes** ☐ No If **no,** please explain.
	Explanation: We do not have grandfathered plans.			
	Page Number: See Schedule of Benefits			
H16G Group Health - Major Medical	**Prohibit Rescissions –** Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We do not have grandfathered plans.			
	Page Number: COC, Section 5, pages 47-50			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16G Group Health - Major Medical	**Preventive Services –** Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: COC, Section 1.90, page 26; Schedule of Benefits; Women's Preventive Amendment			
H16G Group Health - Major Medical	**Extends Dependent Coverage for Children Until age 26 –** If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☑ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We do not have grandfathered plans.			
	Page Number: COC, Section 3.1.2, pages 40-41			
H16G Group Health - Major Medical	**Appeals Process –** Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: COC, Section 12, pages 117-124			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16G Group Health - Major Medical	**Emergency Services** – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: COC, Section 1.12, pages 13-14; COC,Section 1.80, pages 24-25			
H16G Group Health - Major Medical	**Access to Pediatricians** – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: N/A - This is a PPO plan and does not mandate the selection of PCP.			
	Page Number:			
H16G Group Health - Major Medical	**Access to OB/GYNs** – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: NA - This is a PPO plan and does not require prior authorization or referral for OBGYNs.			
	Page Number:			